COPY

-Application

Chattanooga Endoscopy Center

CN1506-024

DSG Development Support Group

June 9, 2015

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application Submittal
Chattanooga Endoscopy Center
Chatanooga, Hamilton County

Dear Mrs. Hill:

This letter transmits an original and two copies of the subject application. The affidavit and filing fee are enclosed.

I am the contact person for this project. Please advise me of any additional information you may need. We look forward to working with the Agency on this project.

Respectfully,

John Wellborn

John Wellborn
Consultant

4219 Hillsboro Road, Suite 203
Nashville, TN 37215

jwdsg@comcast.net

Tel 615.665.2022
Fax 615.665.2042

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

JOHN WELLBORN, being first duly sworn, says that he is the lawful agent of the applicant named in this application, that this project will be completed in accordance with the application to the best of the agent's knowledge, that the agent has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of the agent's knowledge.

John L Wellborn
SIGNATURE/TITLE
CONSULTANT

Sworn to and subscribed before me this 9th day of June (Month), 2015 (Year) a Notary Public in and for the County/State of DAVIDSON

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

Jan M. J
NOTARY PUBLIC

My commission expires 07/02 (Month/Day), 2018 (Year).

CHATTANOOGA ENDOSCOPY CENTER

CERTIFICATE OF NEED APPLICATION TO CHANGE LOCATION AND TO ADD SURGICAL CAPACITY

Submitted June 2015

PART A

1. Name of Facility, Agency, or Institution

Chattanooga Endoscopy Center		
Name		
1501 Riverside Drive, Suite 117		Hamilton
Street or Route		*County*
Chattanooga	TN	37406
City	*State*	*Zip Code*

2. Contact Person Available for Responses to Questions

John Wellborn		Consultant	
Name		*Title*	
Development Support Group		jwdsg@comcast.net	
Company Name		*E-Mail Address*	
4219 Hillsboro Road, Suite 210	Nashville	TN	37215
Street or Route	*City*	*State*	*Zip Code*
CON Consultant	615-665-2022	615-665-2042	
Association With Owner	*Phone Number*	*Fax Number*	

3. Owner of the Facility, Agency, or Institution

The Chattanooga Endoscopy ASC, LLC	615-340-3521	
Name	*Phone Number*	
AmSurg (c/o Jillian Wright, Vice President Operations)		
1A Burton Hills Boulevard		Davidson
Street or Route		*County*
Nashville	TN	37215
City	*State*	*Zip Code*

4. Type of Ownership or Control (Check One)

A. Sole Proprietorship		F. Government (State of TN or Political Subdivision)	
B. Partnership		G. Joint Venture	
C. Limited Partnership		H. Limited Liability Company	*x*
D. Corporation (For-Profit)		I. Other (Specify):	
E. Corporation (Not-for-Profit)			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

5. *Name of Management/Operating Entity (If Applicable)*

AmSurg Corp		
Name		
1A Burton Hills Blvd, Suite 500		Davidson
Street or Route		*County*
Nashville	TN	37215
City	*State*	*Zip Code*

6. *Legal Interest in the Site of the Institution (Check One)*

A. Ownership		D. Option to Lease	
B. Option to Purchase		E. Other (Specify):	
C. Lease of __15__ Years	x		

7. *Type of Institution (Check as appropriate—more than one may apply)*

A. Hospital (Specify): General		I. Nursing Home	
B. Ambulatory Surgical Treatment Center (ASTC) Multi-Specialty		J. Outpatient Diagnostic Center	
C. ASTC, Single Specialty	x	K. Recuperation Center	
D. Home Health Agency		L. Rehabilitation Center	
E. Hospice		M. Residential Hospice	
F. Mental Health Hospital		N. Non-Residential Methadone	
G. Mental Health Residential Facility		O. Birthing Center	
H. Mental Retardation Institutional Habilitation Facility (ICF/MR)		P. Other Outpatient Facility (Specify):	
		Q. Other (Specify):	

8. *Purpose of Review (Check as appropriate—more than one may apply*

A. New Institution		G. Change in Bed Complement Please underline the type of Change: Increase, Decrease, Designation, Distribution, Conversion, Relocation	
B. Replacement/Existing Facility	x	H. Change of Location	x
C. Modification/Existing Facility		I. Other (Specify):	
D. Initiation of Health Care Service as defined in TCA Sec 68-11-1607(4) (Specify)		Increase surgical rooms	x
E. Discontinuance of OB Service			
F. Acquisition of Equipment			

9. *Bed Complement Data* *NOT APPLICABLE*

(Please indicate current and proposed distribution and certification of facility beds.)

	Current Licensed Beds	**CON approved beds (not in service)**	**Staffed Beds**	**Beds Proposed (Change)**	**TOTAL Beds at Completion**
A. Medical					
B. Surgical					
C. Long Term Care Hosp.					
D. Obstetrical					
E. ICU/CCU					
F. Neonatal					
G. Pediatric					
H. Adult Psychiatric					
I. Geriatric Psychiatric					
J. Child/Adolesc. Psych.					
K. Rehabilitation					
L. Nursing Facility (non-Medicaid certified)					
M. Nursing Facility Lev. 1 (Medicaid only)					
N. Nursing Facility Lev. 2 (Medicare only)					
O Nursing Facility Lev. 2 (dually certified for Medicare & Medicaid)					
P. ICF/MR					
Q. Adult Chemical Dependency					
R. Child/Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL					

10. Medicare Provider Number:	3288313
Certification Type:	ASTC
11. Medicaid Provider Number:	3099619
Certification Type:	ASTC

12. & 13. See page 4

A.12. IF THIS IS A NEW FACILITY, WILL CERTIFICATION BE SOUGHT FOR MEDICARE AND/OR MEDICAID?

The applicant is an existing facility that already participates in both Medicare and TennCare/Medicaid. The change of site will not impact that because the licensee remains unchanged.

A.13. IDENTIFY ALL TENNCARE MANAGED CARE ORGANIZATIONS / BEHAVIORAL HEALTH ORGANIZATIONS (MCO'S/BHO'S) OPERATING IN THE PROPOSED SERVICE AREA. WILL THIS PROJECT INVOLVE THE TREATMENT OF TENNCARE PARTICIPANTS? Yes IF THE RESPONSE TO THIS ITEM IS YES, PLEASE IDENTIFY ALL MCO'S WITH WHICH THE APPLICANT HAS CONTRACTED OR PLANS TO CONTRACT.

DISCUSS ANY OUT-OF-NETWORK RELATIONSHIPS IN PLACE WITH MCO'S/BHO'S IN THE AREA.

Chattanooga Endoscopy Center is contracted with three of Tennessee's four MCO's. At the time of this application, it has submitted its credentialing application to Amerigroup and is awaiting an agreement.

Table One: Contractual Relationships with Service Area MCO's	
Available TennCare MCO's	**Applicant's Relationship**
AmeriGroup	contract requested and pending
United Healthcare Community Plan	contracted
BlueCare	contracted
TennCare Select	contracted
Georgia Medicaid	contracted

SECTION B: PROJECT DESCRIPTION

B.I. PROVIDE A BRIEF EXECUTIVE SUMMARY OF THE PROJECT NOT TO EXCEED TWO PAGES. TOPICS TO BE INCLUDED IN THE EXECUTIVE SUMMARY ARE A BRIEF DESCRIPTION OF PROPOSED SERVICES AND EQUIPMENT, OWNERSHIP STRUCTURE, SERVICE AREA, NEED, EXISTING RESOURCES, PROJECT COST, FUNDING, FINANCIAL FEASIBILITY AND STAFFING.

Proposed Services and Equipment

• Chattanooga Endoscopy Center ("CEC") is an ambulatory surgical treatment center (ASTC) limited to endoscopy. It has operated for seventeen years at its current location near Parkridge Medical Center. It has three procedure rooms. Its medical staff has almost quadrupled this year--increasing from four to fifteen gastroenterologists. It will be operating at capacity by late 2015, and does not have sufficient capacity for more than 66% of the cases that the medical staff are asking to perform there.

• This application is to relocate a short distance (three miles) to much larger leased space on Riverside Drive in Chattanooga, with five procedure rooms plus one shelled procedure room for future growth. Pre- and post-operative (recovery) stations will also be expanded, as will all support spaces. Accessibility to patients will be improved.

Ownership Structure

• The facility is owned by The Chattanooga Endoscopy Center, ASC, LLC, which has thirteen members. AmSurg Corp, the original majority member of the facility, has a 35% membership interest. Twelve of the fifteen gastroenterologists on the medical staff share the remaining 65% interest in approximately equal percentages. AmSurg has a management contract with the facility.

• Attachment A.4 contains more details, an organization chart, and information on the Tennessee facilities owned by AmSurg.

Service Area

• The project's primary service area, from which approximately 84% of its cases will come, consists of three Tennessee counties (Hamilton; Bradley; Marion) and two Georgia counties (Walker; Catoosa). This reflects the recent historical patient origin of the newly enlarged medical staff.

Need

• The newly expanded medical staff are requesting capacity to perform 11,442 cases at the CEC. AmSurg can reach 2,500 cases per procedure room in optimal conditions in its endoscopy centers; but this will allow only 7,500 cases to be performed at the three-room CEC. At the optimal AmSurg number, 11,442 annual cases will require five rooms (11,442 / 2,500 = 4.6) A complement of 5 finished procedure rooms is being requested.

• Having 5 procedure rooms will be consistent with State Health Plan criteria for an applicant's internal needs. The Plan states that optimal utilization of a dedicated outpatient procedure room is 1,867 cases (70% of full capacity). In Year One at the new location, the CEC will operate at an average of 2,308 cases per room. That is 123.6% of the optimal level in the State Health Plan. It is 86.5% of full capacity (2,667 cases) as defined in the State Health Plan.

• It is timely to propose the relocation and expansion. The CEC has added all the procedure room and pre- and post-recovery spaces available in its current leased space. No other space in its building space is adequate or available for further expansion. Whereas CEC utilization was only 40.8% in 2014, in 2015 CEC utilization has been escalating rapidly. April utilization was 240% of January utilization, as new physicians began moving their cases to the CEC. Cases will continue to increase. In all of 2015, the CEC is projecting almost 2,000 cases per room per year--well above the State Plan expansion benchmark of 1,868 cases per room per year.

Existing Resources

• In the Tennessee portion of the primary service area, there are four ASTC's that report performing endoscopies. Their combined utilization of all surgery rooms (OR's and procedure rooms) increased from 999 cases per room in 2012 to 1,237 cases per room in 2014. That was an increase of approximately 24% in average area utilization.

* In the Georgia primary service area counties, there is one facility that reports endoscopic surgeries--Hutcheson Medical Center in Fort Oglethorpe. That facility, which is in bankruptcy proceedings, has an overall surgical room utilization of 213 cases per surgical room in 2013--a 49% decline in efficiency since 2011.

Project Cost, Funding, Financial Feasibility

• The cost for CON purposes is estimated at $8,623,911. However, that includes the new location's lease expense over fifteen years and the value of equipment being moved to the new location. Excluding these items, the actual new capital cost of this project is estimated at $5,853,848. All of that will be provided in the form of a loan from AmSurg Corp., a 35% minority owner and manager of this facility. CEC reported a positive operating margin in 2014. Continued positive operating margins are anticipated at the new location, with expanded caseloads.

Staffing

• CEC today has seventeen FTE's. In Years One and Two at the new location, the expanded CEC projects having thirty FTE's on staff, with the largest increases being in RN's, LPN's, and endoscopy techs.

B.II. PROVIDE A DETAILED NARRATIVE OF THE PROJECT BY ADDRESSING THE FOLLOWING ITEMS AS THEY RELATE TO THE PROPOSAL.

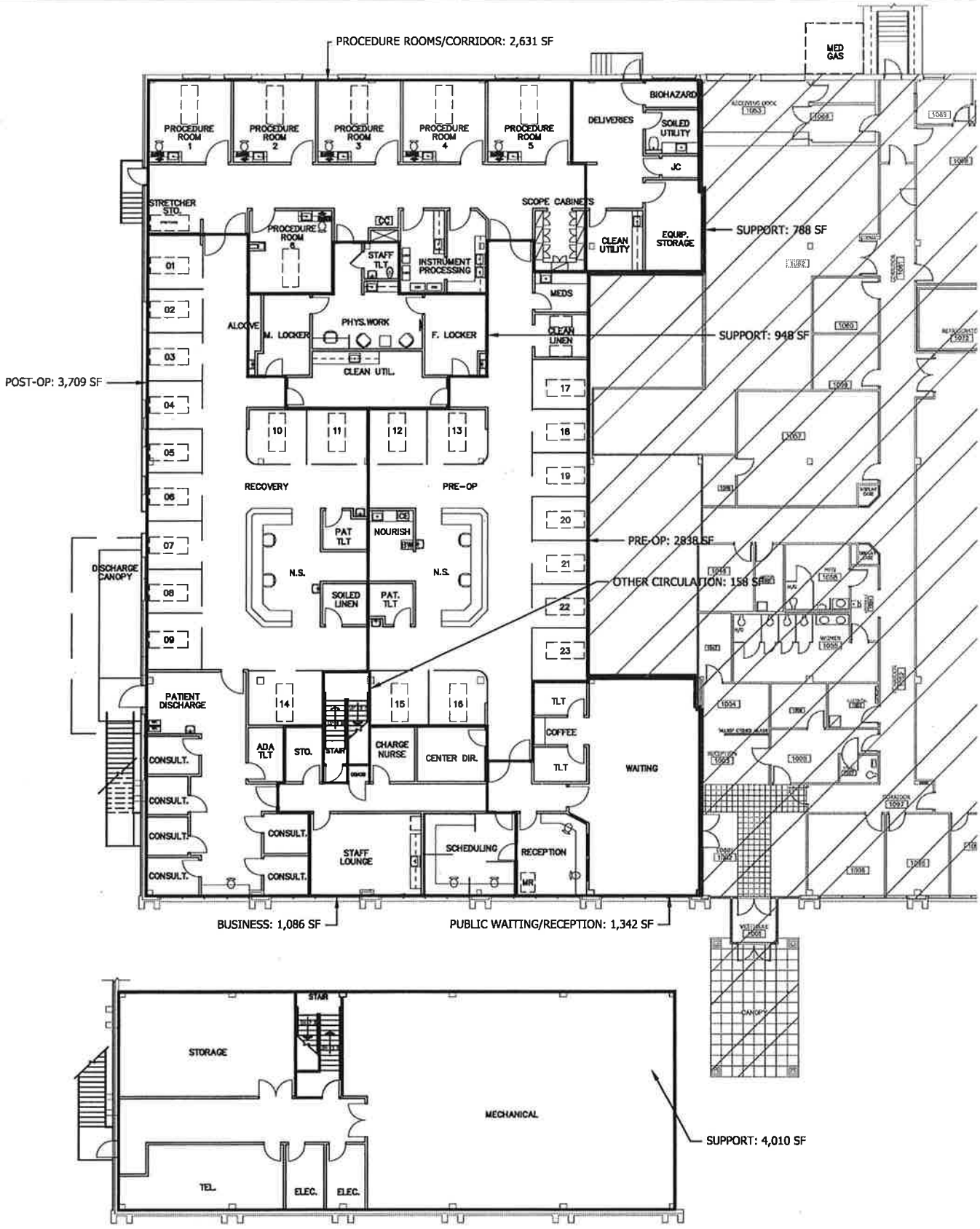
B.II.A. DESCRIBE THE CONSTRUCTION, MODIFICATION AND/OR RENOVATION OF THE FACILITY (EXCLUSIVE OF MAJOR MEDICAL EQUIPMENT COVERED BY T.C.A. 68-11-1601 *et seq.)* INCLUDING SQUARE FOOTAGE, MAJOR OPERATIONAL AREAS, ROOM CONFIGURATION, ETC.

Physical Description of the Project

The applicant facility is a single-specialty ambulatory surgical treatment center limited to endoscopy. It has been located at 2341 McCallie Avenue, Plaza 3, Suite 303 in Chattanooga since its original licensure in 1998, seventeen years ago. Its name prior to June 1, 2015 was the "Digestive Disorders Endoscopy Center". That name was changed this year to "Chattanooga Endoscopy Center" (abbreviated to "CEC" below).

CEC at its present location has 3 procedure rooms, the third of which was made operational in early 2015, in response to a major increase (almost a quadrupling) of its active medical staff. It is increasing its pre- and post-op spaces from 8 to 13 spaces in a building project that will be completed by July 1, 2015, giving it 5,790 SF of space.

In this application, the CEC proposes to move in late 2016 to leased first-floor space at the Riverside Business Center at 1501 Riverside Drive, Suite 117, Chattanooga--a distance of approximately 3 miles from its current location. At the new location, it will have 5 endoscopy procedure rooms plus shelled space for a 6th endoscopy room, with a total space of 17,510 SF--comprised of 13,500 SF of surgery center space on the first floor, plus the use of a 4,010 SF mechanical/electrical room on a "mezzanine" interstitial level above the ASTC floor. (The latter is not leasable for occupancy under codes, so it is not included in the lease document square footage.) It will expand its preparation and recovery areas from its current 5 pre-op stations and 8 recovery stations, to 11 pre-op stations and 12 post-op recovery stations at the new location. The design includes a reception and waiting area, a scheduling room, offices and patient consultation rooms, two nursing stations, and clinical and staff support areas. Its proposed floor plan follows this page. The new location offers both staff and patients much improved parking spaces, and ground-floor entry into the endoscopy center--neither of which is available at its current location.



Digestive Disorders Endoscopy Center Relocation

HMK ARCHITECTS PLLC

JUNE 4, 2015 - PROPOSED PLAN

NOT FOR CONSTRUCTION

17,510 USABLE SF

NOT TO SCALE

Construction Scope and Cost

Tables Two-A and -B below summarize the scope of proposed changes in size and the applicant's build-out/renovation costs at the proposed Riverside Drive location.

Table Two-A: Summary of Construction and Changes in Size	
Facility At Current Site (as of 7-1-15)	5,790 SF
Facility At Proposed New Location	17,510 SF
Area of New Construction	none
Area of Buildout or Renovation	17,510 SF of renovation
Total New & Renovated Construction	17,510 SF of renovation

Table Two-B: Construction Costs of This Project			
	Renovated Construction	**New Construction**	**Total Project**
Square Feet	17,510	none	17,510
Construction Cost	$3,464,500	none	$3,464,500
Constr. Cost PSF	$197.86	none	$197.86

Operational Schedule

CEC will maintain its current operating hours of 7 am to 4 pm, Monday through Friday, throughout the year. Calendar year 2017 is projected to be the first full year of operation at the new location.

Cost and Funding

The cost for CON purposes is estimated at $8,623,911. However, that includes the new location's lease expense over fifteen years and the value of equipment being moved to the new location. Excluding these items, the actual new capital cost of this project is estimated at $5,853,848. All of that will be provided in the form of a loan from AmSurg Corp., a 35% minority owner and manager of this facility.

Because the applicant is including one shelled-in procedure room that may be needed for future expansion, and the date of its opening will depend on future caseloads several years from now, the applicant has included in the project cost the full expense of making that sixth procedure room operational, if and when that occurs.

Ownership

Chattanooga Endoscopy Center will continue to be owned by The Chattanooga Endoscopy ASC, LLC. Membership of the LLC will be unchanged by the relocation. Its members and their interests are shown in Table Two-C below. All physician members are credentialed members of its medical staff, as are three additional non-owning physicians whose names are listed after Table Two-C. Its medical staff totals 15 gastroenterologists, making it the largest gastroenterology staff in its region.

Table Two-C: Membership of The Chattanooga Endoscopy ASC, LLC

Owner's Names	Address	Membership (%)
AmSurg Holdings, Inc.	1A Burton Hills Blvd Nashville, TN 37215	35.000%
1. Sumeet Bhushan, MD	2200 East Third Street, Ste 200 Chattanooga, TN 37404	5.416%
2. Chad Charapta, MD	2201 East Third Street, Ste 200 Chattanooga, TN 37404	5.416%
3. David N. Collins, MD	721 Glenwood Drive, Ste E690 Chattanooga, TN 37404	5.416%
4. Donald Hetzel, MD	2515 DeSales Avenue, Ste 206 Chattanooga, TN 37404	5.416%
5. Scott Manton, MD	2515 DeSales Avenue, Ste 206 Chattanooga, TN 37404	5.416%
6. Gregory Olds, MD	2205 East Third Street, Ste 200 Chattanooga, TN 37404	5.416%
7. Henry Paik, MD	2341 McCallie Avenue, Ste 402 Chattanooga, TN 37404	5.417%
8. Vijay Patel, MD	2515 DeSales Avenue, Ste 206 Chattanooga, TN 37404	5.416%
9.Chattanoga Gastroenterology, PC (Richard Sadowitz, MD)	2341 McCallie Avenue, Ste 400 Chattanooga, TN 37404	5.417%
10. Colleen Schmitt, MD	2209 East Third Street, Ste 200 Chattanooga, TN 37404	5.416%
11. Alan Shikoh, MD	721 Glenwood Drive, Ste W473 Chattanooga, TN 37404	5.416%
12. Larry Shuster, MD	2211 East Third Street, Ste 200 Chattanooga, TN 37404	5.416%

Source: AmSurg

Additional Medical Staff Who Are Not LLC Members:

13. Munford Yates, MD
14. Camille Somer, MD
15. Richard Krause, MD

APPLICANTS WITH HOSPITAL PROJECTS (CONSTRUCTION COST IN EXCESS OF $5 MILLION) AND OTHER FACILITY PROJECTS (CONSTRUCTION COST IN EXCESS OF $2 MILLION) SHOULD COMPLETE THE SQUARE FOOTAGE AND COSTS PER SQUARE FOOTAGE CHART....

See Attachment B.II.A.

PLEASE ALSO DISCUSS AND JUSTIFY THE COST PER SQUARE FOOT FOR THIS PROJECT.

Surgery center construction projects approved by the HSDA in 2011-2013 had the following construction costs per SF:

Ambulatory Surgery Center Construction Cost PSF Years: 2011-2013			
	Renovated Construction	New Construction	Total Construction
1st Quartile	$95.04/sq ft	$174.88/sq ft	$113.55/sq ft
Median	$113.55/sq ft	$223.62/sq ft	$162.00/sq ft
3rd Quartile	$150.00/sq ft	$269.76/sq ft	$223.62/sq ft

Source: HSDA Registry; CON approved applications for years 2011 through 2013

The Chattanooga Endoscopy Center project is above the third quartile for renovation projects at ASTC's. The project's estimated renovation cost is approximately $197.86 PSF overall (for 17,510 SF of space). This is reasonable due to the steady annual increase in construction costs since 2011. The construction will be paid for in 2016, which is four years beyond the midpoint of the HSDA 2011-13 range.

Table Two-B (Repeated): This Project's Construction Costs			
	Renovated Construction	**New Construction**	**Total Project**
Square Feet	17,510	none	17,510
Construction Cost	$3,464,500	none	$3,464,500
Constr. Cost PSF	$197.86	none	$197.86

The HSDA has just released the 2012-2014 ASTC construction cost averages; but there were too few samples to calculate renovation vs. new construction costs.

Ambulatory Surgery Center Construction Cost PSF Years: 2012-2014			
	Renovated Construction	New Construction	Total Construction
1st Quartile	$0/sq ft	$0/sq ft	$113.55/sq ft
Median	$0/sq ft	$0/sq ft	$150.00/sq ft
3rd Quartile	$0/sq ft	$0/sq ft	$174.88/sq ft

Source: HSDA Registry; CON approved applications for years 2012 through 2014

IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.

Not applicable.

B.II.B. IDENTIFY THE NUMBER AND TYPE OF BEDS INCREASED, DECREASED, CONVERTED, RELOCATED, DESIGNATED, AND/OR REDISTRIBUTED BY THIS APPLICATION. DESCRIBE THE REASONS FOR CHANGE IN BED ALLOCATIONS AND DESCRIBE THE IMPACT THE BED CHANGE WILL HAVE ON EXISTING SERVICES.

Not applicable to an ambulatory surgical treatment facility.

B.II.C. AS THE APPLICANT, DESCRIBE YOUR NEED TO PROVIDE THE FOLLOWING HEALTH CARE SERVICES (IF APPLICABLE TO THIS APPLICATION): (NEW SERVICE LIST OMITTED)....

Not applicable. No services are being added to this facility. This is a relocation of an existing facility with no change in its scope of services.

B.II.D. DESCRIBE THE NEED TO CHANGE LOCATION OR REPLACE AN EXISTING FACILITY.

Need for Additional Procedure Room Capacity at the CEC

Earlier this year, several gastroenterology practices in Chattanooga began to concentrate a large portion of their outpatient cases at the Chattanooga Endoscopy Center (CEC), where they have majority (65%) membership in the LLC that owns the facility.

The 11,442 endoscopy cases that they project performing there exceed the current capacity of the 17-year-old facility, which has only 3 procedure rooms. AmSurg Corp, the former majority owner of the CEC, has welcomed their initiative, has reorganized membership of the LLC to accommodate them, has scaled back to a 35% minority membership position with a management contract, and is proposing to relocate the endoscopy center in late 2016 to larger leased space on Riverside Drive in Chattanooga. The proposed endoscopy center there will be able to accommodate all the physicians' projected cases, to provide room for future growth, and to operate well above the level of case-per-room efficiency prescribed in the State Health Plan.

In 2014, with only 4 gastroenterologists active at CEC, and only 2 procedure rooms, CEC (then named the "Digestive Disorders Endoscopy Center") performed 2,173 case, an average of 1,087 cases per room. Currently, in 2015, CEC's utilization is climbing rapidly, due to an almost quadrupling of its medical staff and the addition of a 3rd procedure room in January of this year. April's monthly cases were 240% of January's cases, for example.

Table Three: 2015 Escalation of Utilization at the CEC

	Cases	Annualized (Run Rate)	Annual Cases Per Procedure Room
CY2014	2,173	2,173	1,087 (2 rooms)
CY2015			
January	172	2,064	1,032 (2 rooms)
February	327	3,924	1,308 (3 rooms)
March	399	4,788	1,596 (3 rooms)
April	414	4,968	1,656 (3 rooms)
State Plan Target	467	5,604	1,868 (3 rooms)

Source: CEC Records and AmSurg.

Once the facility reaches 467 cases per month, it will be operating at an annual rate of 1,868 cases per room per year. That will comply with the 1,867-case State Health Plan benchmark for expansion of capacity. The applicant expects to surpass that level of utilization in mid-2015, once additional pre- and post-op spaces are completed. (Until they are available, the new third procedure room cannot be fully scheduled because limited recovery space is limiting its use--creating a bottleneck and limiting productivity.)

Even with 5 additional recovery stations, 3 procedure rooms will not be enough to meet medical staff needs.

The physicians have estimated that out of the more than 20,000 outpatient endoscopies they are already performing annually in Chattanooga, they need to perform 11,442 cases at CEC in 2017. CEC's 3 rooms will have difficulty exceeding 2,500 cases per room. Their throughput will be no more than 7,500 total cases--66% of the cases the medical staff wants to perform there.

To identify needed capacity, AmSurg has applied a 2,500-case-per-room standard to the 11,442-case target, which identifies a need for 4.6 (i.e., 5) procedure rooms. That is the finished room complement being requested in this application. (Shell space for a future 6th room will be included in the construction). Expanding the surgical capacity will also require expansion of the pre-and post-op spaces and almost all support and staff areas. It would not be feasible to undertake such an extensive construction process on-site while maintaining patient care. So relocation is being proposed, allowing for a seamless move to new space over a weekend.

Areawide Needs

Several factors have combined to bring about this concentration of cases at one location. Providers and physicians are increasingly partnering together to increase productivity, lower costs, restrain pricing, and continuously improve quality of care and surgical outcomes. This proposed facility will create the largest gastroenterology facility in its region, offering economies of scale that will permit very competitive pricing and

quality-controlled outcomes. That is needed, in a healthcare economy where payors and patients are aggressively seeking changes.

The general surgery center where five of CEC's new medical staff have been owners and practitioners until recently, is now owned by Memorial Hospital. It has a very large floor plan, and a very high lease cost, that participating physicians believe are no longer sustainable. An orderly relocation of most of its outpatient endoscopies to other ambulatory settings has already occurred. AmSurg and CEC have committed to provide an optimal setting for fifteen of its gastroenterologists' cases going forward, without the cost burdens associated with that surgery center.

Improved Physical Accessibility

The new location offers both staff and patients readily available parking spaces, and ground-floor entry into the endoscopy center--neither of which is available at its current location on a congested tertiary hospital campus. Staff now have to park remotely and take a hospital shuttle bus to their place of employment. Patients have continuous difficulty finding a parking place near the MOB where the CEC is located. Once parked, they must also take an elevator up to CEC. All of these inconveniences will be eliminated at the new location.

B.II.E. DESCRIBE THE ACQUISITION OF ANY ITEM OF MAJOR MEDICAL EQUIPMENT (AS DEFINED BY THE AGENCY RULES AND THE STATUTE) WHICH EXCEEDS A COST OF $1.5 MILLION; AND/OR IS A MAGNETIC RESONANCE IMAGING SCANNER (MRI), POSITRON EMISSION TOMOGRAPHY (PET) SCANNER, EXTRACORPOREAL LITHOTRIPTER AND/OR LINEAR ACCELERATOR BY RESPONDING TO THE FOLLOWING:

1. **For fixed site major medical equipment (not replacing existing equipment):**
    a. **Describe the new equipment, including:**
        1. **Total Cost (As defined by Agency Rule);**
        2. **Expected Useful Life;**
        3. **List of clinical applications to be provided; and**
        4. **Documentation of FDA approval.**
    b. **Provide current and proposed schedule of operations.**
2. **For mobile major medical equipment:**
    a. **List all sites that will be served;**
    b. **Provide current and/or proposed schedule of operations;**
    c. **Provide the lease or contract cost;**
    d. **Provide the fair market value of the equipment; and**
    e. **List the owner for the equipment.**
3. **Indicate applicant's legal interest in equipment (e.g., purchase, lease, etc.) In the case of equipment purchase, include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.**

Not applicable. No major medical equipment is proposed in this project.

B.III.A. ATTACH A COPY OF THE PLOT PLAN OF THE SITE ON AN 8-1/2" X 11" SHEET OF WHITE PAPER WHICH MUST INCLUDE:

1. **SIZE OF SITE (IN ACRES);**
2. **LOCATION OF STRUCTURE ON THE SITE;**
3. **LOCATION OF THE PROPOSED CONSTRUCTION; AND**
4. **NAMES OF STREETS, ROADS OR HIGHWAYS THAT CROSS OR BORDER THE SITE.**

PLEASE NOTE THAT THE DRAWINGS DO NOT NEED TO BE DRAWN TO SCALE. PLOT PLANS ARE REQUIRED FOR ALL PROJECTS.

See Attachment B.III.A.

B.III.B.1. DESCRIBE THE RELATIONSHIP OF THE SITE TO PUBLIC TRANSPORTATION ROUTES, IF ANY, AND TO ANY HIGHWAY OR MAJOR ROAD DEVELOPMENTS IN THE AREA. DESCRIBE THE ACCESSIBILITY OF THE PROPOSED SITE TO PATIENTS/CLIENTS.

The proposed site is very accessible to all parts of the service area. Bradley County residents living northeast of Chattanooga come into Chattanooga via I-75. North Hamilton County residents come via US 27. Walker and Catoosa County patients living south and southeast of the city come into the city via US 27 and I-75. Marion County residents drive to Chattanooga primarily on I-24. Once in Chattanooga, patients have easy access to the Riverside Drive site, using TN 58/Riverside Drive, and local streets such as McCallie Avenue, North Holzclaw, and Wilcox Boulevard.

Chattanooga's municipal bus service (Chattanooga Area Rapid Transit Authority, or CARTA) does provide access to the proposed site on Riverside Drive. Please see the CARTA bus route map in Attachment C,Need--3, Service Area Maps.

The drive time tables on the following page provide driving distance and times between both the current and proposed sites, and major communities in the service area, and from the proposed site to other ASTC's that currently perform endoscopic surgery.

The relocation will significantly improve physical accessibility for CEC patients, who currently encounter delays in finding a parking space at the hospital MOB where the CEC is now located, and who then have to take a building elevator to the CEC on an upper floor. In the new location, there is ample surface parking around the building and the CEC will have its own ground-floor entrance and a canopy to shelter discharged patients.

Table Four-A: Mileage and Drive Times From the Applicant's Current and Proposed Sites to Major Communities in the Project's Primary Service Area					
		To Proposed Site		To Current Site	
County	**City**	**Miles**	**Minutes**	**Miles**	**Minutes**
Hamilton	East Ridge	8.1	21"	4.9	14"
	Red Bank	7.0	13"	18.1	18"
	Soddy Daisy	18.2	21"	19.4	26"
	Ooltewah	17.4	23"	14.3	22"
	Collegedale	19.2	26"	16.1	24"
	Signal Mountain	9.5	17"	10.6	23"
Marion	Jasper	27.9	33"	28.3	36"
	Whitwell	24.9	39"	26.0	45"
	So. Pittsburg	32.9	39"	33.4	45"
	Monteagle	49.2	48"	49.7	50"
Bradley	Cleveland	31.5	37"	28.4	35"
Walker GA	Ft. Ogelthorpe	9.9	26"	7.2	18"
Catoosa GA	Ringgold	16.5	29"	13.6	23"
Unweighted Average Time			**28.6"**		**29.2"**

Source: Google Maps, May 22, 2015.

Table Four-B: Mileage and Drive Times Between the Project and Other ASTC's Performing Endoscopies in the Project's Tennessee Primary Service Area			
Facility and Address	**County and State**	**Distance in Miles**	**Drive Time in Minutes**
Associates of Memorial/Mission OP ASC 2515 DeSales Avenue, Chattanooga, TN 37404	Hamilton TN	0.9	3"
Physicians Surgery Center of Chattanooga 924 Spring Creek Road, Chattanooga, TN 37412	Hamilton TN	3.9	11"
The Surgery Center of Cleveland 137 25th Street, Cleveland, TN 37311	Bradley TN	32.7	40"

Source: Google Maps, May 22, 2015.

B.IV. ATTACH A FLOOR PLAN DRAWING FOR THE FACILITY WHICH INCLUDES PATIENT CARE ROOMS (NOTING PRIVATE OR SEMI-PRIVATE), ANCILLARY AREAS, EQUIPMENT AREAS, ETC.

See attachment B.IV.

IV. FOR A HOME CARE ORGANIZATION, IDENTIFY

1. **EXISTING SERVICE AREA (BY COUNTY);**
2. **PROPOSED SERVICE AREA (BY COUNTY);**
3. **A PARENT OR PRIMARY SERVICE PROVIDER;**
4. **EXISTING BRANCHES AND/OR SUB-UNITS; AND**
5. **PROPOSED BRANCHES AND/OR SUBUNITS.**

Not applicable. The application is not for a home care organization.

C(I) NEED

C(I).1. DESCRIBE THE RELATIONSHIP OF THIS PROPOSAL TO THE IMPLEMENTATION OF THE STATE HEALTH PLAN AND TENNESSEE'S HEALTH: GUIDELINES FOR GROWTH.

A. PLEASE PROVIDE A RESPONSE TO EACH CRITERION AND STANDARD IN CON CATEGORIES THAT ARE APPLICABLE TO THE PROPOSED PROJECT. DO NOT PROVIDE RESPONSES TO GENERAL CRITERIA AND STANDARDS (PAGES 6-9) HERE.

B. APPLICATIONS THAT INCLUDE A CHANGE OF SITE FOR A HEALTH CARE INSTITUTION, PROVIDE A RESPONSE TO GENERAL CRITERION AND STANDARDS (4)(a-c).

Project-Specific Review Criteria: Ambulatory Surgical Treatment Centers (2012 State Health Plan)

Assumptions in Determination of Need

The need for an ambulatory surgical treatment center shall be based upon the following assumptions:

1. Operating Rooms

a. An operating room is available 250 days per year, 8 hours per day.
b. The estimated average time per Case in an Operating Room is 65 minutes.
c. The average time for clean up and preparation between Operating Room Cases is 30 minutes.
d. The optimum utilization of a dedicated, outpatient, general-purpose Operating Room is 70% of full capacity. 70% x 250 days/year x 8 hours/day divided by 95 minutes = 884 Cases per year.

Criteria 1a-1d above are not applicable. The facility will not have any Operating Rooms; it will have only Procedure Rooms.

2. Procedure Rooms

a. A procedure room is available 250 days per year, 8 hours per day.

Complies. The endoscopy center is operated from 7 am to 4 pm Monday through Friday, at least 50 weeks per year. The same hours will be kept at the new location.

b. The estimated average time per outpatient Case in a procedure room is 30 minutes.

Complies. The average time per case (excluding room turnaround) is projected to be 25 minutes.

c. The average time for clean up and preparation between Procedure Room Cases is 15 minutes.

Complies. The average time allowed for room turnaround between endoscopy cases is projected to be 10 minutes.

d. The optimum utilization of a dedicated, outpatient, general-purpose outpatient Procedure Room is 70% of full capacity. 70% x 250 days/year x 8 hours/day divided by 45 minutes = 1867 Cases per year.

Complies. The facility's newly expanded 15-person medical staff has projected performing at least 11,442 cases in the facility's 5 procedure rooms. That will be an average of 2,288 cases per year in each procedure room in 2017. A sixth shelled room can be completed and made operational in future years, if needed.

Determination of Need

1. Need. The minimum numbers of 884 Cases per Operating Room and 1867 Cases per Procedure Room are to be considered as baseline numbers for purposes of determining Need. An applicant should demonstrate the ability to perform a minimum of 884 Cases per Operating Room and/or 1867 Cases per Procedure Room per year, except that an applicant may provide information on its projected case types and its assumptions of estimated average time and clean up and preparation time per Case if this information differs significantly from the above-stated assumptions. It is recognized that an ASTC may provide a variety of services/Cases and that as a result the estimated average time and clean up and preparation time for such services/Cases may not meet the minimum numbers set forth herein. It is also recognized that an applicant applying for an ASTC Operating Room(s) may apply for a Procedure Room, although the anticipated utilization of that Procedure Room may not meet the base guidelines contained here. Specific reasoning and explanation for the inclusion in a CON application of such a Procedure Room must be provided. An applicant that desires to limit its Cases to a specific type or types should apply for a Specialty ASTC.

The endoscopic cases to be performed in this proposed facility will average 2,288 cases per room, with 5 proposed rooms. The applicant does not require exceptions to the criterion of 1,867 or more cases per procedure room at the proposed location.

2. Need and Economic Efficiencies. An applicant must estimate the projected surgical hours to be utilized per year for two years based on the types of surgeries to be performed, including the preparation time between surgeries. Detailed support for estimates must be provided.

The following estimates are based on AmSurg's extensive experience operating and managing this type of facility. AmSurg operates the nation's largest system of endoscopy centers. These case times could be longer or shorter, depending on the mix of low and high acuity cases that will be brought to the CEC, which is difficult to project at this point.

Year One (11,442 cases)

a. Average surgical time for endoscopy case: 25 minutes

b. Average room turnaround time: 10 minutes

c. Total average minutes per case: **35 minutes**

d. Available time in 6 procedure rooms:

60 minutes per hour X 8 hours per day X 250 days per year X 5 procedure rooms = 600,000 minutes of surgical room time available per year

e. Time required to perform Year One projected volume of 11,442 cases:

11,442 cases X 35 total average minutes per case = 400,470 minutes required per year

f. Utilization or Occupancy Rate of Procedure Rooms =

400,470 minutes utilized / 600,000 minutes available =**67% average utilization**

Year Two (11,542 cases)

a. Average surgical time for endoscopy case: 25 minutes

b. Average room turnaround time: 10 minutes

c. Total average minutes per case: **35 minutes**

d. Available time in 6 procedure rooms:

60 minutes per hour X 8 hours per day X 250 days per year X 5 procedure rooms = 600,000 minutes of surgical room time available per year

e. Time required to perform Year One projected volume of 11,542 cases:

11,542 X 35 total average minutes per case = 403,970 minutes required per year

f. Utilization or Occupancy Rate of Procedure Rooms =

403,970 minutes utilized / 600,000 minutes available =**67% average utilization**

3. Need; Economic Efficiencies; Access. To determine current utilization and need, an applicant should take into account both the availability and utilization of either: a) all existing outpatient Operating Rooms and Procedure Rooms in a Service Area, including physician office based surgery rooms (when those data are officially reported and available) OR b) all existing comparable outpatient Operating Rooms and Procedure Rooms based on the type of Cases to be performed. Additionally, applications should provide similar information on the availability of nearby out-of-state existing outpatient Operating Rooms and Procedure Rooms, if that data are available, and provide the source of that data. Unstaffed dedicated outpatient Operating Rooms and unstaffed dedicated outpatient Procedure Rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.

Tennessee Primary Service Area Counties--Hamilton, Bradley, Marion

In Tennessee, hospital and surgery center utilization is reported only in the Joint Annual Reports (JAR's). The JARs report each facility's inpatient and outpatient case data and its numbers of operating and procedure rooms.

However, the JARs do not report the cases done in operating rooms separately from the cases done in procedure rooms.

Because of that, when an applicant is proposing to add only procedure rooms, it is not possible to calculate just procedure room utilization for the service area, or to calculate the procedure room utilization at a surgery center that has both operating rooms and procedure rooms. The only data that can be calculated is utilization of total facility and service area "surgical rooms" (operating rooms plus procedure rooms).

In Sections B.II.C. above and C(I)5-6 below, the applicant has presented the publicly available data on utilization of area surgery centers that perform endoscopies (i.e., excluding eye surgery centers, plastic surgery centers, etc. which do not have gastroenterologists on staff). In 2014, the 4 service area facilities that reported endoscopy utilization averaged 1,237 cases per surgical room--i.e., in 8 procedure rooms and 18 operating rooms. Hospital endoscopy volumes are not reported in hospital JARs.

Georgia Primary Service Area Counties (Walker, Catoosa)

There are only two surgical facilities in the two Georgia counties (Walker and Catoosa) in the applicant's primary service area. They are Hutcheson Medical Center, an acute care hospital in Fort Oglethorpe (Walker County), and "Hutcheson on the Parkway", Hutcheson Medical Center's outpatient services department in nearby Ringgold (Catoosa) County. Utilization data from Hutcheson Medical Center is provided in Table 9-B in Section C(I)5-6 below. The applicant did not find utilization data on the Ringgold facility reported on any State of Georgia website.

It should be noted that Hutcheson filed for bankruptcy recently, and is being sued by Erlanger Medical Center in Chattanooga for repayment of funds advanced to their failed joint effort to manage Hutcheson back to financial stability. The Hutcheson system, regardless of its surgical capacity, is miles south of Chattanooga and cannot realistically be regarded as an acute care resource for patients who are already choosing to use Tennessee gastroenterologists practicing in Chattanooga. The Georgia cases projected for the CEC in this CON application are not speculative; they are Georgia patients actually served in 2014 by the physicians of the applicant CEC.

4. Need and Economic Efficiencies. An applicant must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON application to establish an ASTC or to expand existing services of an ASTC should not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed, if those services are known and relevant, within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above.

Areawide Utilization

Available data does not allow for a calculation of the utilization of comparable procedure rooms in the service area. Endoscopies are almost always performed in non-sterile procedure rooms rather than in sterile operating rooms. Tennessee's publicly available data sources do not show the utilization rate of non-sterile procedure rooms only, within hospitals and surgery centers that have both operating rooms and procedure rooms.

The Applicant's Utilization

However, under this criterion, the applicant's "current" utilization is relevant. In 2014, with only 4 gastroenterologists actively using the facility, and only 2 rooms open, the Chattanooga Endoscopy Center (then named the Digestive Disorders Endoscopy Center) performed 2,173 cases in its 2 procedure rooms, which was an average of 1,087 cases per room.

Currently, its utilization is climbing rapidly, due to expansion of the medical staff (which has almost quadrupled to 15 gastroenterologists) and to the addition of a 3rd procedure room this year:

Table Five: 2015 Escalation of Utilization at the CEC

	Cases	Annualized (Run Rate)	Annual Cases Per Procedure Room
CY2014	2,173		1,087 (2 rooms)
CY2015			
January	172	2,064	1,032 (2 rooms)
February	327	3,924	1,308 (3 rooms)
March	399	4,788	1,596 (3 rooms)
April	414	4,968	1,656 (3 rooms)
State Plan Target	467	5,604	1,868 (3 rooms)

Once the facility reaches 467 cases per month, this will be an annual rate of 1,868 cases per room per year. At that point, the current utilization of the CEC at its present location will meet the 1,867-case criterion. That will probably be reached in the third quarter of 2015, as additional pre- and post-op spaces are completed to remove bottlenecks that are limiting the full use of the third procedure room.

Impact on Other Facilities

Of the 11,442 projected cases in Year One, an estimated 2,152 will be from physicians already on staff in 2014 and using the CEC for their cases. An estimated 9,290 new cases will be brought by the physicians who have been performing cases at

other facilities. This number has been provided by the physicians themselves but without specific information on the number and locations of those cases--except that they have been performing most or all of them at two facilities: Memorial Healthcare System (main hospital) and Associates of Memorial/Mission Outpatient Surgery Center.

The applicant does not have access to the private records of either the physicians or those other facilities, so has no precise knowledge of impact on those facilities.

5. Need and Economic Efficiencies. An application for a Specialty ASTC should present its projections for the total number of cases based on its own calculations for the projected length of time per type of case, and shall provide any local, regional, or national data in support of its methodology. An applicant for a Specialty ASTC should provide its own definitions of the surgeries and/or procedures that will be performed and whether the Surgical Cases will be performed in an Operating Room or a Procedure Room. An applicant for a Specialty ASTC must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON proposal to establish a Specialty ASTC or to expand existing services of a Specialty ASTC shall not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above. An applicant that is granted a CON for a Specialty ASTC shall have the specialty or limitation placed on the CON.

The applicant will perform only outpatient gastroenterology cases, to which it is currently limited. No change in that limitation is being requested.

The applicant will perform these cases solely in procedure rooms. No operating rooms are available at the current location and none will be available at the new location.

The other information requested in criterion #5 duplicates information already provided in response to criteria #2 and #4. Please see the applicant's responses to those criteria with respect to:

- Case time analysis based on applicant's own experience;
- Impact on other area facilities;
- Utilization data from other comparable facilities in the primary service area.

See also Section C(I)5 below for tables and narrative of utilization data in comparable facilities in the service area.

Other Standards and Criteria

6. Access to ASTCs. The majority of the population in a Service Area should reside within 60 minutes average driving time to the facility.

Complies. See drive time tables in Section B.III.B.1 above.

7. Access to ASTCs. An applicant should provide information regarding the relationship of an existing or proposed ASTC site to public transportation routes if that information is available.

There is bus service available to the Riverside Business Park on Riverside Drive. A bus route map has been provided in Attachment C, Need--3.

8. Access to ASTCs. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must

- **project the origin of potential patients by percentage and county of residence and, if such data are readily available, by zip code, and**
- **must note where they are currently being served.**
- **Demographics of the Service Area should be included, including the anticipated provision of services to out-of-state patients, as well as**
- **the identity of other service providers both in and out of state and the source of out-of-state data. Applicants shall document all other provider alternatives available in the Service Area.**
- **All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.**

Patient Origin: This is provided in Sections C(I)3-4. The primary service area will consist of Hamilton, Bradley, and Marion Counties in Tennessee, and Walker and Catoosa Counties in Georgia. Zip code patient origin from so many practices is not readily available.

Places of Current Service: The applicant's information from its medical staff is that 2,152 of the projected cases will come from physicians already practicing at the CEC in 2014 before its medical staff expanded this year. The new physicians estimate that another 9,290 cases will be brought to CEC, cases previously done at the Associates of Memorial/Mission Outpatient Surgery Center and Memorial Healthcare System. In 2015, all are being done at Memorial Healthcare (the main hospital).

Demographics of the Service Area: This is provided in Section C(I)4.A.

Service Area Providers: The Tennessee Joint Annual Reports ("JARs") for Hospitals do not provide statistics on the number of endoscopies, or the endoscopies performed in the hospital's OR's, or the endoscopies performed in procedure rooms. The JAR's for Ambulatory Surgical Treatment Centers who have both OR's and procedure rooms do state the number of endoscopy patients at the facility--however, they do not report the endoscopy utilization of OR's, separately from the endoscopy utilization of procedure rooms. So except for a surgery center with only procedure rooms, it is not possible to identify the specific endoscopy procedure room utilization. The applicant has provided all available utilization data for all area surgery centers reporting endoscopy cases; but it is limited to each facility's total case utilization of all surgical rooms, and the number and percent of its total cases that were endoscopies. See Section C(I)5 below.

Assumptions--Each section's responses identifies its assumptions and sources of data.

9. Access and Economic Efficiencies. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient utilization for each of the first eight quarters following completion of the project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

The quarterly projection table below is based on annual case estimates made by the medical staff in writing. The Year One estimate was 11,442 cases. Year Two was increased to 11,542 by the applicant. The physician estimates are provided in their letter in Attachment C, Need--1.A.3. Quarterly breakdowns were distributed approximately evenly.

Table Six: Chattanooga Endoscopy Center
Projection of Quarterly Cases, Years One and Two

	Q1 Cases	Q2 Cases	Q3 Cases	Q4 Cases	Total
2017	2,860	2,860	2,861	2,861	11,422
2018	2,885	2,885	2,886	2,886	11,542

10. Patient Safety and Quality of Care; Health Care Workforce.

a. An applicant should be or agree to become accredited by any accrediting organization approved by the Centers for Medicare and Medicaid Services, such as the Joint Commission, the Accreditation Association of Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgical Facilities, or other nationally recognized accrediting organization.

The applicant is already AAAHC-accredited and is committed to maintaining its accreditation.

b. An applicant should estimate the number of physicians by specialty that are expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel. An applicant should provide documentation on the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.

The medical staff consists of fifteen gastroenterologists, Board Certified in Internal Medicine (15) and also in Gastroenterology (14). Board documentation is provided in Attachment C-Need--1.A.3. The CEC requires that physicians applying for surgical or anesthesia privileges be Board-certified or Board-eligible in their appropriate specialties, along with other customary criteria. See Attachment

Attachment C-Need--1.A. contains documentation of appropriate anesthesiology coverage.

11. Access to ASTCs. In light of Rule 0720-11.01, which lists the factors concerning need on which an application may be evaluated, and Principle No. 2 in the State Health Plan, *"Every citizen should have reasonable access to health care,"* the HSDA may decide to give special consideration to an applicant:

a. Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration;

The CEC's primary service area consists of Hamilton, Bradley, and Marion Counties in Tennessee, and Walker and Catoosa Counties in Georgia. Parts of all five counties are designated as medically underserved areas. They are identified in Attachment C-Need-1.A.

b. Who is a "safety net hospital" or a "children's hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program;

Not applicable.

c. Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program;

The applicant so commits. The applicant already contracts with Medicare, and with three of the four TennCare MCO's in the area. The applicant is awaiting acceptance of a contract by the fourth MCO. The applicant is contracted to Georgia Medicaid.

d. Who is proposing to use the ASTC for patients that typically require longer preparation and scanning times. The applicant shall provide in its application information supporting the additional time required per Case and the impact on the need standard.

Not applicable. The applicant's case times are not longer than the criteria.

Project-Specific Review Criteria: Construction, Renovation, Expansion, and Replacement of Health Care Institutions

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

Not applicable; none of these changes is being proposed.

2. For relocation or replacement of an existing licensed healthcare institution:

a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strngths and weaknesses of each alternative.

The applicant has provided detailed cost projections for relocation to a new site. Providing plans and budgets for "renovation" is not applicable because the CEC's current location is not in need of renovation. Its expansion is not feasible because the CEC is in a medical office building where it may not be possible to expand capacity. Even were it possible, the applicant intends to move to a location that is "hospital-neutral" by comparison to its current site on the grounds of one major hospital in the area.

b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

The applicant has submitted a signed letter from its medical staff, stating that they collectively estimate bringing 11,422 cases to the proposed new location in its first year. This number was arrived at in consultation with one another and with AmSurg. As their letter states, they perform much more than that number of outpatient cases currently, at all licensed facilities combined. Their total outpatient cases exceed 20,000.

3. For renovation or expansion of an existing licensed healthcare institution:

a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

b. the applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

Not applicable; this is a replacement project and not a renovation or expansion project.

The Framework for Tennessee's Comprehensive State Health Plan

Five Principles for Achieving Better Health

The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. After each principle, the applicant states how this CON application supports the principle, if applicable.

1. Healthy Lives

The purpose of the State Health Plan is to improve the health of Tennesseans.
Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.

The project represents the collaboration of an established surgical provider with multiple groups of gastroenterologists serving patients from more than five area counties.

2. Access to Care

Every citizen should have reasonable access to health care.
Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.

The project pays careful attention to accessibility, both from financial and physical perspectives. The applicant has contracts with three of the four TennCare MCO's now operating Statewide; and is seeking a contract with the fourth MCO. The applicant is contracted with Georgia Medicaid (provider #803344479A). The proposed site is very physically accessible to the service area counties in terms of drive time.

3. Economic Efficiencies

The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. **The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.**

The project will provide an efficient facility for the delivery of care, one which conforms to current codes and design standards. This will be done in a setting that costs Medicare approximately 30%-40% less than if the same surgeries were performed in a hospital or in a hospital-based outpatient department.

4. Quality of Care

Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. **Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.**

AmSurg Corp and the physician members of the applicant LLC are committed to processes of continuous quality improvement and the delivery of cost-effective "best practices" medical care.

5. Health Care Workforce

The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. **The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.**

The project has no apparent net impact on the healthcare workforce.

C(I).2. DESCRIBE THE RELATIONSHIP OF THIS PROJECT TO THE APPLICANT'S LONG-RANGE DEVELOPMENT PLANS, IF ANY.

The CEC does not prepare long-range development plans.

C(I).3. IDENTIFY THE PROPOSED SERVICE AREA AND JUSTIFY THE REASONABLENESS OF THAT PROPOSED AREA. SUBMIT A COUNTY-LEVEL MAP INCLUDING THE STATE OF TENNESSEE CLEARLY MARKED TO REFLECT THE SERVICE AREA. PLEASE SUBMIT THE MAP ON A 8-1/2" X 11" SHEET OF WHITE PAPER MARKED ONLY WITH INK DETECTABLE BY A STANDARD PHOTOCOPIER (I.E., NO HIGHLIGHTERS, PENCILS, ETC.).

The applicant's physicians had more than 31,000 patient visits in 2014. Their patient origin data indicates a primary service area consisting of Hamilton, Bradley, and Marion Counties in Tennessee, and Walker and Catoosa Counties in Georgia. Approximately 84% of their patient visits came from those five counties.

This project assumes that the CEC service area at the new location on Riverside Drive will be the same. Table Seven on the following page shows the projected patient origin for Years One and Two of the project. Approximately 63% of the CEC patients will come from the three Tennessee primary service area counties. Approximately 21% will come from the two Georgia primary service area counties. The remaining 16% will come from other Tennessee and Georgia counties and other States.

Table Seven: The Chattanooga Endoscopy Center Patient Origin Projection CY2017-18					
County	Patients CY2014	Percent of Total Patients	Cumulative Percent of Total Patients	Year One CY2017 Patients	Year Two CY2018 Patients
Primary Service Area (PSA) Counties					
Hamilton	17,217	54.08%	54.08%	6,188	6,242
Walker (GA)	4,164	13.08%	67.16%	1,497	1,510
Catoosa (GA)	2,594	8.15%	75.31%	932	940
Bradley	1,622	5.09%	80.40%	583	588
Marion	1,116	3.51%	83.91%	401	405
PSA Subtotal	*26,713*	*83.91%*		*9,601*	*9,685*
Secondary Service Area (SSA) Counties and States	*5,124*	*16.09%*		*1,841*	*1,857*
Grand Total	*31,837*	*100.00%*		*11,442*	*11,542*

Source: Medical staff patient origin records and management projections.

C(I).4.A DESCRIBE THE DEMOGRAPHICS OF THE POPULATION TO BE SERVED BY THIS PROPOSAL.

Table Eight data from the Tennessee Department of Health show that this service area's total population will increase from 2015 to 2019, but at a slower rate than the State rate: 1.8% growth in the service area compared to 3.7% Statewide.

Endoscopies are needed primarily by persons 50 years or older. A larger percent of the service area is age 50 or older--37.3% compared to 35.3% Statewide. The area's age 50+ population will increase 4.7% between 2015 and 2019--an increase of almost 11,000 persons, all of whom should be obtaining endoscopies every decade, or at shorter intervals recommended by their physicians.

The service area's median household income is very close to that of the State; and the service area has a slightly lower percent of residents living in poverty--17.0% compared to 17.6% Statewide. Approximately 18.8% of the service area population is enrolled in Medicaid or TennCare, compared to 21% across all of Tennessee.

Table Seven: The Chattanooga Endoscopy Center Patient Origin Projection CY2017-18					
County	Patients CY2014	Percent of Total Patients	Cumulative Percent of Total Patients	Year One CY2017 Patients	Year Two CY2018 Patients
Primary Service Area (PSA) Counties					
Hamilton	17,217	54.08%	54.08%	6,188	6,242
Walker (GA)	4,164	13.08%	67.16%	1,497	1,510
Catoosa (GA)	2,594	8.15%	75.31%	932	940
Bradley	1,622	5.09%	80.40%	583	588
Marion	1,116	3.51%	83.91%	401	405
PSA Subtotal	*26,713*	*83.91%*		*9,601*	*9,685*
Secondary Service Area (SSA) Counties and States	*5,124*	*16.09%*		*1,841*	*1,857*
Grand Total	*31,837*	*100.00%*		*11,442*	*11,542*

Source: Medical staff patient origin records and management projections.

C(I).4.B. DESCRIBE THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION, INCLUDING HEALTH DISPARITIES, THE ACCESSIBILITY TO CONSUMERS, PARTICULARLY THE ELDERLY, WOMEN, RACIAL AND ETHNIC MINORITIES, AND LOW-INCOME GROUPS. DOCUMENT HOW THE BUSINESS PLANS OF THE FACILITY WILL TAKE INTO CONSIDERATION THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION.

The need for periodic screening and other endoscopies is now considered universal for all persons 50 years of age and older (45 years of age or older for African-Americans), in order to prevent avoidable deaths from colon cancer. This is a need shared by all, regardless of gender, race, ethnicity, or income level.

Chattanooga Endoscopy Center is open to all of the above groups. It contracts with three of Tennessee's TennCare plans, and will be contracted to a fourth plan in the near future. It contracts with Georgia Medicaid. For persons without adequate insurance, discounting and periodic payment plans are worked out individually prior to service, with eligibility based on income. CEC participates in "Colonoscopy Assist", an organization for providing discounted colonoscopy screenings for uninsured and underinsured persons. Charitable discounts were calculated for the Historic and Projected Data Charts in this application.

Table Eight: The Chattanooga Endoscopy Center
Demographic Characteristics of Primary Service Area
2015-2019

Demographic	HAMILTON County	BRADLEY County	MARION County	WALKER Co GA	CATOOSA Co GA	PROJECT PSA	STATE OF TENNESSEE
Median Age-2010 US Census	39.3	38.2	42.3	39.7	38.3	40	37.8
Total Population-2015	349,273	104,364	28,652	67,823	66,202	616,314	6,649,438
Total Population-2019	354,610	108,511	29,125	67,072	67,983	627,301	6,894,997
Total Population-% Change 2015 to 2019	1.5%	4.0%	1.7%	-1.1%	2.7%	1.8%	3.7%
Age 50+ Population-2015	130,117	37,844	11,800	25,903	24,141	229,805	2,346,357
% of Total Population	37.3%	36.3%	41.2%	38.2%	36.5%	37.3%	35.3%
Age 50+ Population-2019	134,011	40,929	12,099	26,456	27,220	240,715	2,490,254
% of Total Population	37.8%	37.7%	41.5%	39.4%	40.0%	38.4%	36.1%
Age 50+ Population-% Change 2015-2019	3.0%	8.2%	2.5%	2.1%	12.8%	4.7%	6.1%
Median Household Income	$46,702	$41,083	$41,268	$39,963	$47,087	$43,221	$44,298
Medicaid Enrollees (4/15)	64,491	21,356	6,920	12,959	9,957	115,683	1,399,004
Percent of 2015 Population Enrolled in Medicaid	18.5%	20.5%	24.2%	19.1%	15.0%	18.8%	21.0%
Persons Below Poverty Level (2014)	57,979	20,664	5,301	11,326	9,202	104,473	1,170,301
Persons Below Poverty Level As % of Population (US Census)	16.6%	19.8%	18.5%	16.7%	13.9%	17.0%	17.6%

Sources: TDH Population Projections, May 2013; U.S. Census QuickFacts; GA Dept of Health, OASIS system TennCare Bureau. PSA data is unweighted average or total of county data.

C(I).5. DESCRIBE THE EXISTING OR CERTIFIED SERVICES, INCLUDING APPROVED BUT UNIMPLEMENTED CON'S, OF SIMILAR INSTITUTIONS IN THE SERVICE AREA. INCLUDE UTILIZATION AND/OR OCCUPANCY TRENDS FOR EACH OF THE MOST RECENT THREE YEARS OF DATA AVAILABLE FOR THIS TYPE OF PROJECT. BE CERTAIN TO LIST EACH INSTITUTION AND ITS UTILIZATION AND/OR OCCUPANCY INDIVIDUALLY. INPATIENT BED PROJECTS MUST INCLUDE THE FOLLOWING DATA: ADMISSIONS OR DISCHARGES, PATIENT DAYS, AND OCCUPANCY. OTHER PROJECTS SHOULD USE THE MOST APPROPRIATE MEASURES, E.G., CASES, PROCEDURES, VISITS, ADMISSIONS, ETC.

In the project's Tennessee primary service area, there are 5 ambulatory surgical treatment centers whose Joint Annual Reports indicate that they perform outpatient endoscopies. Their utilization for the past three reporting years, 2012-2014, is shown in Table Nine-A on the following page.

In the Georgia service area counties, the Hutcheson Medical Center in Fort Oglethorpe reports some endoscopies, and its affiliated "Hutcheson on the Parkway" outpatient center in nearby Ringgold advertises a gastroenterology medical staff. However, it is unclear whether the surgery center is the site of any endoscopies, because it appears to have no annual report on Georgia's website for surgery center utilization.

Table Nine-B on the second following page provides what utilization information is available for Hutcheson Medical Center. At Hutcheson, endoscopies are performed in the operating suite. In addition, Hutcheson is in bankruptcy proceedings and is embroiled in litigation brought by Erlanger Medical Center in Chattanooga to recover loans made to Hutcheson in a failed joint effort to make Hutcheson viable.

Table Nine-A: The Chattanooga Endoscopy Center
Primary Service Area Utilization of Ambulatory Surgical Treatment Centers Performing Endoscopies

	2012 Joint Annual Report of ASTC's							
County	Facility Name	O.R.'s	Procedure Rooms	Total Surgical Rooms	Total Cases	Cases Per Surgical Room	GI Endoscopy Cases	GI Endoscopy Cases Percent of Total Cases
Hamilton	Associates of Memorial/Mission Outpatient Surgery Center	4	3	7	11,740	1,677	6,820	58.1%
	Digestive Disorders Endoscopy Center	0	2	2	2,215	1,108	2,215	100.0%
	Physicians Surgery Center of Chattanooga	4	2	6	3,317	553	574	17.3%
	Plaza Surgery Center (last year of operation as ASTC)	4	4	8	3,855	482	463	12.0%
Bradley	The Surgery Center of Cleveland (Novamed in 2012)	2	1	3	4,856	1,619	1,330	27.4%
	TOTAL TENNESSEE PRIMARY SERVICE AREA	14	12	26	25,983	999	11,402	43.9%
	2013 Joint Annual Report of ASTC's							
County	Facility Name	O.R.'s	Procedure Rooms	Total Surgical Rooms	Total Cases	Cases Per Surgical Room	GI Endoscopy Cases	GI Endoscopy Cases Percent of Total Cases
Hamilton	Associates of Memorial/Mission Outpatient Surgery Center	4	3	7	11,491	1,642	6,675	58.1%
	Digestive Disorders Endoscopy Center	0	2	2	2,240	1,120	2,240	100.0%
	Physicians Surgery Center of Chattanooga	4	2	6	3,194	532	599	18.8%
Bradley	The Surgery Center of Cleveland	2	1	3	5,033	1,678	1,494	29.7%
	TOTAL TENNESSEE PRIMARY SERVICE AREA	10	8	18	21,958	1,220	11,008	50.1%
	2014 Joint Annual Report of ASTC's							
County	Facility Name	O.R.'s	Procedure Rooms	Total Surgical Rooms	Total Cases	Cases Per Surgical Room	GI Endoscopy Cases	GI Endoscopy Cases Percent of Total Cases
Hamilton	Associates of Memorial/Mission Outpatient Surgery Center	4	3	7	11,357	1,622	6,417	56.5%
	Digestive Disorders Endoscopy Center	0	2	2	2,173	1,087	2,173	100.0%
	Physicians Surgery Center of Chattanooga	4	2	6	3,384	564	552	16.3%
Bradley	The Surgery Center of Cleveland	2	1	3	5,350	1,783	2,005	37.5%
	TOTAL TENNESSEE PRIMARY SERVICE AREA	10	8	18	22,264	1,237	11,147	50.1%

Note: TN case data is patients reported on page 6 of JARs. GA data fromGA Department of Community Health (2014 not yet published).

Table Nine-B: Hutcheson Medical Center, Walker County Georgia Surgical Utilization			
	2011	**2012**	**2013**
Dedicated Outpatient Operating Rooms	*3*	*3*	*3*
Endoscopy Patients	0	0	0
Other Patients	3,570	1,654	1,741
Total Patients	3,570	1,654	1,741
Shared (IP/OP) Operating Rooms	*4*	*4*	*4*
Endoscopy Patients	9	308	541
Other Patients	624	471	325
Total Patients	633	779	866
Shared Cystoscopy Room	*1*	*1*	*1*
Endoscopy Patients	0	0	0
Other Patients	25	39	87
Total Patients	25	39	87
Total Surgical Rooms	*8*	*8*	*8*
Total Endoscopy Patients	9	308	541
Total Patients	4,219	2,164	2,153
Total Patients per Surgical Room	527	271	269

Source: Georgia Department of Community Health; Oasis Data System
Notes: Endoscopies are done in the OR suite. Georgia reports patients and procedures.

C(I).6. PROVIDE APPLICABLE UTILIZATION AND/OR OCCUPANCY STATISTICS FOR YOUR INSTITUTION FOR EACH OF THE PAST THREE (3) YEARS AND THE PROJECTED ANNUAL UTILIZATION FOR EACH OF THE TWO (2) YEARS FOLLOWING COMPLETION OF THE PROJECT. ADDITIONALLY, PROVIDE THE DETAILS REGARDING THE METHODOLOGY USED TO PROJECT UTILIZATION. THE METHODOLOGY MUST INCLUDE DETAILED CALCULATIONS OR DOCUMENTATION FROM REFERRAL SOURCES, AND IDENTIFICATION OF ALL ASSUMPTIONS.

Recent Utilization

Before 2015, CEC's name was the "Digestive Disorders Endoscopy Center". In 2014, with only 4 gastroenterologists on staff at the CEC, and only 2 procedure rooms operational, it performed 2,173 cases-- an average of 1,087 cases per room. Currently, in 2015, CEC's utilization is escalating rapidly. This is due to a recent almost quadrupling of its medical staff (from 4 to 15 members), and to the opening of a 3rd procedure room in January of this year:

Table Five (Repeated from Prior Section): 2015 Escalation of Cases at the CEC

	Cases	Annualized (Run Rate)	Annual Cases Per Procedure Room
CY2014	2,173	2,173	1,087 (2 rooms)
CY2015			
January	172	2,064	1,032 (2 rooms)
February	327	3,924	1,308 (3 rooms)
March	399	4,788	1,596 (3 rooms)
April	414	4,968	1,656 (3 rooms)
State Plan Target	467	5,604	1,868 (3 rooms)

Source: CEC Records and AmSurg.

Once the facility reaches 467 cases per month, it will be operating at an annual rate of 1,868 cases per room per year. That will comply with the 1,867-case State Health Plan benchmark for expansion of capacity. The applicant expects to surpass that level of utilization in Q3 of 2015, once additional pre- and post-op spaces are completed. Until they are available, the new third procedure room can't be fully utilized because limited recovery space is creating a bottleneck in the surgery rooms.

Even with the additional recovery stations, 3 procedure rooms will not be enough to meet medical staff needs.

CEC's physicians have estimated that of the more than 20,000 outpatient endoscopies they already perform annually in Chattanooga, they intend to schedule 11,442 of them at CEC in 2017. At CEC's current capacity of only 3 rooms, it will have difficulty exceeding 2,500 cases per room. CEC's optimal utilization limit will therefore be 7,500 total cases--only two-thirds (66%) of the cases the medical staff wants to perform there.

To identify what number of rooms would be adequate, AmSurg applied a 2,500-case-per-room standard to the 11,442-case target. That identified a need for 4.6 (i.e., 5) procedure rooms--the finished room complement being requested in this application. It is also prudent to have potential expansion capacity so a shelled 6th room is included.

Historic and Projected Utilization

Table 9-A above provided historical utilization of the applicant CEC. Table Ten below expands that data to include projections for 2015-2018.

Table Ten: Chattanooga Endoscopy Center
Historical and Projected Utilization 2012-2018

Calendar Year	Procedure Rooms	Cases	Cases Per Room	Annual Utilization Based On AmSurg Optimal Cases of 2,500 / Rm	Percent of State Health Plan Optimal Cases of 1,867 / Rm	Percent of State Health Plan Full Capacity Cases of 2,667 / Rm
2012	2	2,215	1,108	44.3%	59.3%	41.5%
2013	2	2,240	1,120	44.8%	60.0%	42.0%
2014	2	2,113	1,087	42.3%	58.2%	40.8%
2015	3	5,890	1,963	78.5%	105.1%	73.6%
2016	3	7,500	2,500	100.0%	133.9%	93.7%
2017-Yr 1	5	11,442	2,288	91.5%	122.6%	85.8%
2018-Yr 2	5	11,542	2,308	92.3%	123.6%	86.5%

Source: AmSurg management and medical records.

Table Ten's projection assumptions are as follows:

- 2015--Q1 is 898, the actual number of cases. Q2 is 1,242, based on three times the April actual cases of 414. Q3 and Q4 total 3,750 cases (625 cases per month, the practical limit of productivity in 3 rooms, after expansion of pre- and post-op spaces).
- 2016 --625 cases per month based on the practical limit of productivity in 3 rooms (c. 208.3 per room) after addition of more pre- and post-op spaces at the end of 2015.
- 2017--based on medical staff estimates of the cases they currently have and feel are appropriate to bring to the CEC.
- 2018--an increase of 100 annual cases over 2017.

C(II)1. PROVIDE THE COST OF THE PROJECT BY COMPLETING THE PROJECT COSTS CHART ON THE FOLLOWING PAGE. JUSTIFY THE COST OF THE PROJECT.

• ALL PROJECTS SHOULD HAVE A PROJECT COST OF AT LEAST $3,000 ON LINE F (MINIMUM CON FILING FEE). CON FILING FEE SHOULD BE CALCULATED ON LINE D.

• THE COST OF ANY LEASE (BUILDING, LAND, AND/OR EQUIPMENT) SHOULD BE BASED ON FAIR MARKET VALUE OR THE TOTAL AMOUNT OF THE LEASE PAYMENTS OVER THE INITIAL TERM OF THE LEASE, WHICHEVER IS GREATER. NOTE: THIS APPLIES TO ALL EQUIPMENT LEASES INCLUDING BY PROCEDURE OR "PER CLICK" ARRANGEMENTS. THE METHODOLOGY USED TO DETERMINE THE TOTAL LEASE COST FOR A "PER CLICK" ARRANGEMENT MUST INCLUDE, AT A MINIMUM, THE PROJECTED PROCEDURES, THE "PER CLICK" RATE AND THE TERM OF THE LEASE.

• THE COST FOR FIXED AND MOVEABLE EQUIPMENT INCLUDES, BUT IS NOT NECESSARILY LIMITED TO, MAINTENANCE AGREEMENTS COVERING THE EXPECTED USEFUL LIFE OF THE EQUIPMENT; FEDERAL, STATE, AND LOCAL TAXES AND OTHER GOVERNMENT ASSESSMENTS; AND INSTALLATION CHARGES, EXCLUDING CAPITAL EXPENDITURES FOR PHYSICAL PLANT RENOVATION OR IN-WALL SHIELDING, WHICH SHOULD BE INCLUDED UNDER CONSTRUCTION COSTS OR INCORPORATED IN A FACILITY LEASE.

• FOR PROJECTS THAT INCLUDE NEW CONSTRUCTION, MODIFICATION, AND/OR RENOVATION; DOCUMENTATION MUST BE PROVIDED FROM A CONTRACTOR AND/OR ARCHITECT THAT SUPPORT THE ESTIMATED CONSTRUCTION COSTS.

The architect's letter supporting the construction cost estimate is provided in Attachment C, Economic Feasibility--1.

On the Project Costs Chart, following this response:

Line A.1, A&E fees, were estimated by the project architect.

Line A.2, legal, administrative, and consultant fees, include a contingency for expenses of legal counsel in the event of opposition.

Line A.5, construction cost, was calculated by AmSurg development staff.

Line A.6, contingency, was estimated at 10% of construction costs in line A.5.

Line A.7 includes both fixed and moveable equipment costs, estimated by AmSurg development staff.

Line B.1 is the fair market value of the facility being leased. It was calculated in the two alternative ways required by staff rules. The lease outlay was the larger of these two alternative calculations and was used in Line B.1.

Lease Outlay Method:

The lease sets forth an annual lease payment schedule for the 15-year term of the lease. The total of those payments is $2,008,682.71.

Pro Rata Building Value Method:

The lease for this space specifies a payment only for the 13,500 SF of space on the main surgery center floor. The lessor is not charging the applicant for the use of the 4,010 SF mezzanine-level electrical/telephone/mechanical room beneath the surgery center floor. Using the entire 17,510 ASTC premises, the FMV is: 17,510 SF / 136,778 SF building X $6,300,000 building value (per tax records) = $806,511.

Line B.5 is the value of existing equipment being relocated to the project.

Line C.1, interim financing, was estimated as follows: (Part A + Part E costs) X 1/2 X 5% interest X 1 year = $147,049.

PROJECT COSTS CHART-- THE CHATTANOOGA ENDOSOPY CENTER

A.	Construction and equipment acquired by purchase:		
1.	Architectural and Engineering Fees		$ 248,000
2.	Legal, Administrative, Consultant Fees (Excl CON Filing)		50,000
3.	Acquisition of Site		0
4.	Preparation of Site		0
5.	Construction Cost		3,464,500
6.	Contingency Fund	10% of A5	346,450
7.	Fixed Equipment (Not included in Construction Contract)		0
8.	Moveable Equipment (List all equipment over $50,000)		1,578,489
9.	Other (Specify)	In A5--misc bldg & inspection fees	0
B.	Acquisition by gift, donation, or lease:		
1.	Facility (inclusive of building and land)		2,008,863
2.	Building only		0
3.	Land only		0
4.	Equipment (Specify)	3 rooms of OR scopes & washers	761,200
5.	Other (Specify)		0
C.	Financing Costs and Fees:		
1.	Interim Financing		147,049
2.	Underwriting Costs		0
3.	Reserve for One Year's Debt Service		0
4.	Other (Specify)		0
D.	Estimated Project Cost (A+B+C)		8,604,551
E.	CON Filing Fee		19,360
F.	Total Estimated Project Cost (D+E)	**TOTAL $**	8,623,911

Actual Capital Cost $5,853,848
Section B FMV $2,770,063

Interim Interest: (A + E) X 1/2 avg balance X 5% x 1 yr
$5,881,948 X .5 X 5% X 1.0 yrs = $147,049
Note: E was lower before interim interest was added to line E.

C(II).2. IDENTIFY THE FUNDING SOURCES FOR THIS PROJECT.

a. PLEASE CHECK THE APPLICABLE ITEM(S) BELOW AND BRIEFLY SUMMARIZE HOW THE PROJECT WILL BE FINANCED. (DOCUMENTATION FOR THE TYPE OF FUNDING MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND IDENTIFIED AS ATTACHMENT C, ECONOMIC FEASIBILITY--2).

___x__A. Commercial Loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

_____B. Tax-Exempt Bonds--copy of preliminary resolution or a letter from the issuing authority, stating favorable contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

_____C. General Obligation Bonds--Copy of resolution from issuing authority or minutes from the appropriate meeting;

_____D. Grants--Notification of Intent form for grant application or notice of grant award;

_____E. Cash Reserves--Appropriate documentation from Chief Financial Officer; or

_____F. Other--Identify and document funding from all sources.

The project will be funded AmSurg Corp, which will loan to the applicant LLC the full actual capital expenses of the project--currently estimated at approximately $5,853,848. Documentation of financing is provided in Attachment C, Economic Feasibility--2, in the form of a letter from the Chief Financial Officer of AmSurg.

C(II).3. DISCUSS AND DOCUMENT THE REASONABLENESS OF THE PROPOSED PROJECT COSTS. IF APPLICABLE, COMPARE THE COST PER SQUARE FOOT OF CONSTRUCTION TO SIMILAR PROJECTS RECENTLY APPROVED BY THE HSDA.

Surgery center construction projects approved by the HSDA in 2011-2013 had the following construction costs per SF:

Ambulatory Surgery Center Construction Cost PSF Years: 2011-2013			
	Renovated Construction	New Construction	Total Construction
1st Quartile	$95.04/sq ft	$174.88/sq ft	$113.55/sq ft
Median	$113.55/sq ft	$223.62/sq ft	$162.00/sq ft
3rd Quartile	$150.00/sq ft	$269.76/sq ft	$223.62/sq ft

Source: HSDA Registry; CON approved applications for years 2011 through 2013

Chattanooga Endoscopy Center's project is above the third quartile for renovation projects at ASTC's. The project's estimated construction cost is approximately $197.86 PSF overall (for 17,510 SF of space). This is reasonable due to the steady annual increase in construction costs since 2011. This construction will be paid for in 2016, which is four years beyond the midpoint of the HSDA 2011-13 range.

Table Two-B (Repeated): This Project's Construction Costs			
	Renovated Construction	**New Construction**	**Total Project**
Square Feet	17,510	none	17,510
Construction Cost	$3,464,500	none	$3,464,500
Constr. Cost PSF	$197.86	none	$197.86

The HSDA has just released the 2012-2014 ASTC construction cost averages; but there were too few samples to calculate renovation vs. new construction costs.

Ambulatory Surgery Center Construction Cost PSF Years: 2012-2014			
	Renovated Construction	New Construction	Total Construction
1st Quartile	$0/sq ft	$0/sq ft	$113.55/sq ft
Median	$0/sq ft	$0/sq ft	$150.00/sq ft
3rd Quartile	$0/sq ft	$0/sq ft	$174.88/sq ft

Source: HSDA Registry; CON approved applications for years 2012 through 2014

C(II).4. COMPLETE HISTORICAL AND PROJECTED DATA CHARTS ON THE FOLLOWING TWO PAGES--DO NOT MODIFY THE CHARTS PROVIDED OR SUBMIT CHART SUBSTITUTIONS. HISTORICAL DATA CHART REPRESENTS REVENUE AND EXPENSE INFORMATION FOR THE LAST THREE (3) YEARS FOR WHICH COMPLETE DATA IS AVAILABLE FOR THE INSTITUTION. PROJECTED DATA CHART REQUESTS INFORMATION FOR THE TWO YEARS FOLLOWING COMPLETION OF THIS PROPOSAL. PROJECTED DATA CHART SHOULD INCLUDE REVENUE AND EXPENSE PROJECTIONS FOR THE PROPOSAL ONLY (I.E., IF THE APPLICATION IS FOR ADDITIONAL BEDS, INCLUDE ANTICIPATED REVENUE FROM THE PROPOSED BEDS ONLY, NOT FROM ALL BEDS IN THE FACILITY).

See the following pages for these charts, with notes where applicable. Please note that these charts and this application use calendar year data rather than the fiscal year (FYE June 30) data in the ASTC Joint Annual Reports.

HISTORICAL DATA CHART -- DIGESTIVE DISORDERS ENDOSCOPY CENTER (NOW CHATTANOOGA ENDOSCOPY CENTER)

Give information for the last three (3) years for which complete data are available for the facility or agency.

The fiscal year begins in January.

			CY 2012	CY 2013	CY 2014
		Cases	2280	2363	2152
A.	Utilization Data				
B.	Revenue from Services to Patients				
	1. Inpatient Services		$		
	2. Outpatient Services		3,945,315	4,295,940	3,958,564
	3. Emergency Services				
	4. Other Operating Revenue				
	(Specify) See notes page				
		Gross Operating Revenue	$ 3,945,315	$ 4,295,940	$ 3,958,564
C.	Deductions for Operating Revenue				
	1. Contractual Adjustments		$ 2,701,721	3,021,504	2,761,454
	2. Provision for Charity Care		28,782	45,931	20,796
	3. Provisions for Bad Debt		2,216	70,143	43,420
		Total Deductions	$ 2,732,719	$ 3,137,578	$ 2,825,670
NET OPERATING REVENUE			$ 1,212,596	$ 1,158,362	$ 1,132,894
D.	Operating Expenses				
	1. Salaries and Wages		$ 382,518	418,391	441,393
	2. Physicians Salaries and Wages				
	3. Supplies		93,822	111,581	118,704
	4. Taxes		60,986	45,948	39,315
	5. Depreciation		60,058	75,548	38,412
	6. Rent		70,357	74,332	82,184
	7. Interest, other than Capital		(967)		
	8. Management Fees				
	a. Fees to Affiliates		48,000	48,000	48,000
	b. Fees to Non-Affiliates				
	9. Other Expenses (Specify)	See notes page	167,408	172,808	226,260
		Total Operating Expenses	$ 882,182	946,608	994,268
E.	Other Revenue (Expenses) -- Net (Specify)		$	$	$
NET OPERATING INCOME (LOSS)			$ 330,414	$ 211,754	$ 138,626
F.	Capital Expenditures				
	1. Retirement of Principal		$	$ 14,577	$ 36,261
	2. Interest		0	1,376	2,977
		Total Capital Expenditures	$ 0	$ 15,953	$ 39,238
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 330,414	$ 195,801	$ 99,388

PROJECTED DATA CHART--CHATTANOOGA ENDOSCOPY CENTER

Give information for the two (2) years following the completion of this proposal.

The fiscal year begins in January.

			CY 2017	CY 2018
	Cases		11,442	11,542
A.	Utilization Data			
B.	Revenue from Services to Patients			
	1. Inpatient Services		$	$
	2. Outpatient Services		21,685,100	22,093,368
	3. Emergency Services			
	4. Other Operating Revenue (Specify)	See notes page		
		Gross Operating Revenue	$ 21,685,100	$ 22,093,368
C.	Deductions for Operating Revenue			
	1. Contractual Adjustments		$ 15,171,419	$ 15,459,382
	2. Provision for Charity Care		76,801	78,247
	3. Provisions for Bad Debt		230,860	232,878
		Total Deductions	$ 15,479,080	$ 15,770,507
NET OPERATING REVENUE			$ 6,206,020	$ 6,322,861
D.	Operating Expenses			
	1. Salaries and Wages		$ 1,573,700	$ 1,620,911
	2. Physicians Salaries and Wages			
	3. Supplies		656,384	681,629
	4. Taxes		161,400	161,400
	5. Depreciation		452,137	452,137
	6. Rent		190,367	181,020
	7. Interest, other than Capital		2,977	2,977
	8. Management Fees			
	a. Fees to Affiliates		0	0
	b. Fees to Non-Affiliates			
	9. Other Expenses (Specify)	See notes page	1,334,050	1,381,704
	Dues, Utilities, Insurance, and Prop Taxes.			
		Total Operating Expenses	$ 4,371,015	$ 4,481,778
E.	Other Revenue (Expenses) -- Net (Specify)		$	$
NET OPERATING INCOME (LOSS)			$ 1,835,005	$ 1,841,083
F.	Capital Expenditures			
	1. Retirement of Principal		$ 836,088	$ 877,893
	2. Interest		284,350	242,546
		Total Capital Expenditures	$ 1,120,438	$ 1,120,439
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 714,567	$ 720,644

THE CHATTANOOGA ENDOSCOPY CENTER

D9--OTHER EXPENSES	HISTORIC DATA CHART			PROJECTED DATA CHART	
	2012	2013	2014	2017	2018
Management Fee to AmSurg--New Location	na	na	na	$186,181	$189,686
7301-0000 Linen service	$8,227	$9,391	$7,884	$43,596	$45,273
7305-0000 Medical waste	$423	$31	$870	$4,812	$4,997
7306-0000 Medical specialist fee	$12,000	$12,000	$12,000	$66,355	$68,907
7309-0000 Billing service	$51,173	$39,397	$41,906	$231,722	$240,635
7321-0000 Collection fees	$2,372	$177	$168	$927	$962
7323-0000 Contract services	$13,531	$13,444	$18,438	$101,952	$105,873
7327-0000 Uniform allowance	$1,549	$1,194	$1,359	$7,517	$7,806
7331-0000 GP travel	$4,116	$3,747	$6,486	$35,867	$37,246
7333-0000 LP travel	$1,393	$1,014	$2,827	$15,631	$16,233
7337-0000 Business meals and entertainment	$2,825	$1,549	$4,933	$27,280	$28,329
7339-0000 Office supplies	$8,875	$12,160	$22,501	$124,423	$129,209
7341-0000 Postage	$675	$92	$386	$2,134	$2,217
7343-0000 Express delivery	$328	$302	$1,039	$5,744	$5,965
7347-0000 Telephone	$7,477	$7,250	$6,524	$36,075	$37,463
7349-0000 Dues and subscriptions	$3,192	$3,155	$5,930	$32,789	$34,050
7351-0000 Meetings and conferences	$583	$1,684	$707	$3,908	$4,058
7353-0000 Maintenance scopes	$209	$0	$20,400	$87,483	$90,848
7355-0000 Maintenance other	$3,914	$18,901	$15,356	$65,850	$68,383
7356-0000 Software maintenance contracts	$9,710	$9,478	$16,023	$68,713	$71,356
7357-0000 Advertising	$4,196	$5,019	$8,189	$35,117	$36,468
7361-0000 Donations and contributions	$100	$1,000	$0	$0	$0
7363-0000 Employee recruiting cost	$245	$916	$1,528	$8,450	$8,775
7369-0000 Other operating expense	$9,539	$14,140	$9,172	$39,334	$40,847
7371-0000 Accreditation fee	$3,739			$0	$0
Total other variable expenses				$0	$0
Fixed expenses:				$0	$0
7412-0000 Rent equipment	$1,817	$1,298	$767	$3,289	$3,416
7421-0000 Insurance malpractice	$7,028	$7,352	$6,787	$37,528	$38,971
7422-0000 Insurance other	$4,720	$5,867	$6,204	$26,606	$27,630
CAM PASS THROUGHS				$0	$0
HOUSEKEEPING				$0	$0
7431-0000 Utilities	$3,818	$4,233	$7,077	$30,349	$31,516
8109-0000 Miscellaneous other income	-$369	-$1,982	-$1,273	-$7,037	-$7,308
8201-0000 Loss on disposition of assets	$0	$0	$2,071	$11,453	$11,893
TOTAL	**$167,408**	**$172,808**	**$226,260**	**$1,334,050**	**$1,381,704**

C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.

Table Eleven: The Chattanooga Endoscopy Center Average Charges, Deductions, and Net Charges		
	CY2017	**CY2018**
Cases	11,422	11,542
Average Gross Charge Per Case	$1,895	$1,914
Average Deduction Per Case	$1,353	$1,366
Average Net Charge (Net Operating Revenue) Per Case	$542	$548
Average Net Operating Income Per Case After Capital Expenditures	$160	$160

C(II).6.A. PLEASE PROVIDE THE CURRENT AND PROPOSED CHARGE SCHEDULES FOR THE PROPOSAL. DISCUSS ANY ADJUSTMENT TO CURRENT CHARGES THAT WILL RESULT FROM THE IMPLEMENTATION OF THE PROPOSAL. ADDITIONALLY, DESCRIBE THE ANTICIPATED REVENUE FROM THE PROPOSED PROJECT AND THE IMPACT ON EXISTING PATIENT CHARGES.

The applicant CEC will not have its gross charge structure modified by this project. Charges in 2017 are expected to be only 3% higher on average than in 2015. Please see Table Thirteen on the second following page.

C(II).6.B. COMPARE THE PROPOSED CHARGES TO THOSE OF SIMILAR FACILITIES IN THE SERVICE AREA/ADJOINING SERVICE AREAS, OR TO PROPOSED CHARGES OF PROJECTS RECENTLY APPROVED BY THE HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).

There are no other dedicated endoscopy centers in the Chattanooga area, so Table Twelve below compares this project's CY 2017 charges to the FYE 2014 charges of Nashville and Knoxville endoscopy centers.

Table Twelve: CEC Charges in CY2017 Compared to FYE 2014 Charges at Other Endoscopy Centers in Knoxville and Nashville

Facility	Cases (Patients)	Gross Charges	Gross Charges Per Case	Net Revenue	Net Revenue Per case
Digest. Disease Endo. Center (Nashville)	6,162	$9,148,179	$1,485	$5,242,063	$851
Nashville Endo. Center (Nashville)	2,870	$11,209,263	$3,906	$2,128,551	$742
The Endoscopy Center (Knoxville)	8,402	$17,668,336	$2,103	$5,367,724	$639
The Endoscopy Center West (Knox)	4,193	$8,937,499	$2,132	$2,501,911	$597
Associated Endoscopy (Nashville)	5,031	$8,220,082	$1,634	$2,902,350	$577
The Endoscopy Center North (Knoxville)	5,353	$11,650,650	$2,176	$3,018,963	$564
Chattanooga Endo. Center (Hamilton) *	2,332	$4,260,120	$1,827	$1,167,730	$501
THIS PROJECT CY 2017	**11,442**	**$21,685,100**	**$1,895**	**$6,206,020**	**$542**
NV GI Endo. Center (Nashville)	2,594	$2,748,480	$1,060	$1,210,816	$467
Mid-State Endo. Center (Nashville)	2,436	$2,697,619	$1,107	$1,108,610	$455
Southern Endo. Center (Nashville)	2,711	$2,707,995	$999	$1,153,111	$425

*Source: 2014 Joint Annual Reports of ASTC's. (*2014 JAR of CEC is being amended to reflect the data in this table.) FYE data reported in the JAR is the only source for comparison. It will not be consistent with the Historical and Projected Data Chart and other tables in this application because these all use calendar year data.*

The following page contains Table Thirteen, showing the CEC's most frequent procedures performed, with their current Medicare reimbursement, and their projected Year One and Two average gross charges.

Table Thirteen: The Chattanooga Endoscopy Center Most Frequent Surgical Procedures and Average Gross Charges Current and Proposed					
			Average Gross Charge		
CPT	Descriptor	Current Medicare Allowable	Current Average	Year 1 CY2017	Year 2 CY2018
43239	Upper gi endoscopy, biopsy	$382.23	$1,485	$1,500	$1,515
45380	Colonoscopy and biopsy	$404.92	$1,485	$1,500	$1,515
45378	Diagnostic colonoscopy	$404.92	$1,485	$1,500	$1,515
43248	Upper gi endoscopy/guide wire	$382.23	$1,485	$1,500	$1,515
45385	Lesion removal colonoscopy	$404.92	$1,485	$1,500	$1,515
G0105	Colorectal scrn; hi risk individual	$335.80	$1,485	$1,500	$1,515
G0121	Colon ca scrn; not high risk	$335.80	$1,485	$1,500	$1,515
43235	Upper gi endoscopy, diagnosis	$382.23	$1,050	$1,061	$1,071
46221	Hemorrhoidectomy	$167.25	$1,050	$1,061	$1,071
45381	Colonoscopy, submuccous inj	$404.92	$1,485	$1,500	$1,515
45330	Flexible Sigmoidoscopy	$93.66	$1,050	$1,061	$1,071
43450	Dilate Esophagus	$382.23	$1,050	$1,061	$1,071
43249	Esoph endoscopy, Dilation	$545.89	$1,485	$1,500	$1,515
43251	Operative upper gi endoscopy	$545.89	$1,485	$1,500	$1,515
45338	Sigmoidoscopy w/tumor removal	$424.17	$1,485	$1,500	$1,515

Source: AmSurg

C(II).7. DISCUSS HOW PROJECTED UTILIZATION RATES WILL BE SUFFICIENT TO MAINTAIN COST-EFFECTIVENESS.

This is an existing endoscopy center whose cases in 2014 were modest in number, but which showed a positive operating margin, and net revenues per case that were below the $582 average for 11 endoscopy centers in Chattanooga, Knoxville, and Nashville. With a 2017 caseload 500% as large as in 2014, CEC is projected to maintain its current cost-effectiveness while improving patient accessibility and improving facility efficiency.

C(II).8. DISCUSS HOW FINANCIAL VIABILITY WILL BE ENSURED WITHIN TWO YEARS; AND DEMONSTRATE THE AVAILABILITY OF SUFFICIENT CASH FLOW UNTIL FINANCIAL VIABILITY IS MAINTAINED.

This existing endoscopy center is financially viable and has a positive cash flow. Its Projected Data Chart for 2017-2018 indicates that this will continue at the new location.

C(II).9. DISCUSS THE PROJECT'S PARTICIPATION IN STATE AND FEDERAL REVENUE PROGRAMS, INCLUDING A DESCRIPTION OF THE EXTENT TO WHICH MEDICARE, TENNCARE/MEDICAID, AND MEDICALLY INDIGENT PATIENTS WILL BE SERVED BY THE PROJECT. IN ADDITION, REPORT THE ESTIMATED DOLLAR AMOUNT OF REVENUE AND PERCENTAGE OF TOTAL PROJECT REVENUE ANTICIPATED FROM EACH OF TENNCARE, MEDICARE, OR OTHER STATE AND FEDERAL SOURCES FOR THE PROPOSAL'S FIRST YEAR OF OPERATION.

Table Fourteen below shows CEC's current overall payor mix. The applicant projects maintaining approximately the same Medicare and TennCare/Medicaid payor mix that is currently being experienced. The Medicare and TennCare/Medicaid payor mix for Year One at the new location are shown in Table Fifteen below.

Table Fourteen: Chattanooga Endoscopy Center 2014-15 Payor Mix

Payor	Percentage
Medicare	32%
TennCare/Medicaid	5%
Blue Cross	30%
Commercial	25%
Other	8%
Total	100%

Table Fifteen: Chattanooga Endoscopy Center Medicare and TennCare/Medicaid Revenues, Year One

	Medicare	TennCare/Medicaid
Gross Revenue	$6,939,232	$1,084,255
Percent of Gross Revenue	32%	5%

C(II).10. PROVIDE COPIES OF THE BALANCE SHEET AND INCOME STATEMENT FROM THE MOST RECENT REPORTING PERIOD OF THE INSTITUTION, AND THE MOST RECENT AUDITED FINANCIAL STATEMENTS WITH ACCOMPANYING NOTES, IF APPLICABLE. FOR NEW PROJECTS, PROVIDE FINANCIAL INFORMATION FOR THE CORPORATION, PARTNERSHIP, OR PRINCIPAL PARTIES INVOLVED WITH THE PROJECT. COPIES MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND LABELED AS ATTACHMENT C, ECONOMIC FEASIBILITY--10.

These are provided as Attachment C, Economic Feasibility--10.

C(II)11. DESCRIBE ALL ALTERNATIVES TO THIS PROJECT WHICH WERE CONSIDERED AND DISCUSS THE ADVANTAGES AND DISADVANTAGES OF EACH ALTERNATIVE, INCLUDING BUT NOT LIMITED TO:

A. A DISCUSSSION REGARDING THE AVAILABILITY OF LESS COSTLY, MORE EFFECTIVE, AND/OR MORE EFFICIENT ALTERNATIVE METHODS OF PROVIDING THE BENEFITS INTENDED BY THE PROPOSAL. IF DEVELOPMENT OF SUCH ALTERNATIVES IS NOT PRACTICABLE, THE APPLICANT SHOULD JUSTIFY WHY NOT, INCLUDING REASONS AS TO WHY THEY WERE REJECTED.

B. THE APPLICANT SHOULD DOCUMENT THAT CONSIDERATION HAS BEEN GIVEN TO ALTERNATIVES TO NEW CONSTRUCTION, E.G., MODERNIZATION OR SHARING ARRANGEMENTS. IT SHOULD BE DOCUMENTED THAT SUPERIOR ALTERNATIVES HAVE BEEN IMPLEMENTED TO THE MAXIMUM EXTENT PRACTICABLE.

The applicant investigated expanding at its present location in the Parkridge Medical Center MOB, but there is not enough space available either adjacent to its present leasehold, or on another floor. Memorial Health System invited the applicant to consider leasing the space now occupied by the Associates of Memorial/Mission ASTC, and a second space on its campus; but neither space was appropriately sized and the lease cost would have been prohibitively high.

At the proposed location, all construction is renovation of existing space; there is no new construction required in this project.

C(III).1. LIST ALL EXISTING HEALTH CARE PROVIDERS (I.E., HOSPITALS, NURSING HOMES, HOME CARE ORGANIZATIONS, ETC.) MANAGED CARE ORGANIZATIONS, ALLIANCES, AND/OR NETWORKS WITH WHICH THE APPLICANT CURRENTLY HAS OR PLANS TO HAVE CONTRACTUAL AND/OR WORKING RELATIONSHIPS, E.G., TRANSFER AGREEMENTS, CONTRACTUAL AGREEMENTS FOR HEALTH SERVICES.

The applicant has transfer agreements in place with TriStar Parkridge Medical Center and with Memorial Health System.

C(III).2. DESCRIBE THE POSITIVE AND/OR NEGATIVE EFFECTS OF THE PROPOSAL ON THE HEALTH CARE SYSTEM. PLEASE BE SURE TO DISCUSS ANY INSTANCES OF DUPLICATION OR COMPETITION ARISING FROM YOUR PROPOSAL, INCLUDING A DESCRIPTION OF THE EFFECT THE PROPOSAL WILL HAVE ON THE UTILIZATION RATES OF EXISTING PROVIDERS IN THE SERVICE AREA OF THE PROJECT.

The project will be beneficial to the health care system. Patients will have easier physical accessibility to parking and to the endoscopy center itself. Also, cases moved from a hospital surgical room to an ASTC surgical room are typically reimbursed at much lower costs by not only Medicare, but also commercial insurers. This saves money for the healthcare system.

The projection for this project in its first year at the new location is 11,442 cases, of which 9,200 are estimated to be cases performed in 2014 largely at Associates of Memorial/Mission Outpatient Surgery Center, and to a lesser extent at Memorial Healthcare System.

But it is important to understand that most of these cases are already moving over to the CEC, and that in 2016 the CEC at its present location can perform 7,500, or 65%, of them. That would leave 3,942 more endoscopic cases to be transferred from other locations, when the CEC opens more surgical capacity on Riverside Drive. Almost all of those will most likely be moved from Memorial's main hospital facility.

C(III).3. PROVIDE THE CURRENT AND/OR ANTICIPATED STAFFING PATTERN FOR ALL EMPLOYEES PROVIDING PATIENT CARE FOR THE PROJECT. THIS CAN BE REPORTED USING FTE'S FOR THESE POSITIONS. IN ADDITION, PLEASE COMPARE THE CLINICAL STAFF SALARIES IN THE PROPOSAL TO PREVAILING WAGE PATTERNS IN THE SERVICE AREA AS PUBLISHED BY THE TENNESSEE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT AND/OR OTHER DOCUMENTED SOURCES.

The Department of Labor and Workforce Development website indicates the following Upper Central Tennessee region's annual salary information for clinical employees of this project:

Table Sixteen: TDOL Surveyed Average Salaries for the Region

Position	Entry Level	Mean	Median	Experienced
RN	$46,246	$57,282	$56,767	$62,800
Medical Assistant	$21,537	$28,410	$26,639	$31,847

Source: TDOLWD 2014 Survey, Chattanooga Area

Table Seventeen on the following page provides current and proposed staffing patterns for the CEC.

Table Seventeen: Chattanooga Endoscopy Center Current and Projected Staffilng				
Position Type (RN, etc.)	**Current FTE'S**	**Year One FTE's**	**Year Two FTE's**	**Annual Salary Range**
Center Administrator (RN)	1	1	1	$80-90k
Charge RNs	2	2	2	$60-70k
Staff RNs	3	5	5	$55-65k
LPNs	1	2	2	$40-50k
Endoscopy Techs	6	14	14	$30-40k
Medical Assistants	0	1	1	$25-30k
Receptionists	2	3	3	$30-40k
Schedulers	2	2	2	$30-40k
Total FTE's	**17**	**30**	**30**	

Source: AmSurg

C(III).4. DISCUSS THE AVAILABILITY OF AND ACCESSIBILITY TO HUMAN RESOURCES REQUIRED BY THE PROPOSAL, INCLUDING ADEQUATE PROFESSIONAL STAFF, AS PER THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, AND/OR THE DIVISION OF MENTAL RETARDATION SERVICES LICENSING REQUIREMENTS.

The applicant has excellent access to pools of clinical personnel in the Southeast Tennessee and north Georgia market. AmSurg recruits both Statewide and nationally for its nurses and other clinical employees.

C(III).5. VERIFY THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSING CERTIFICATION AS REQUIRED BY THE STATE OF TENNESSEE FOR MEDICAL/CLINICAL STAFF. THESE INCLUDE, WITHOUT LIMITATION, REGULATIONS CONCERNING PHYSICIAN SUPERVISION, CREDENTIALING, ADMISSIONS PRIVILEGES, QUALITY ASSURANCE POLICIES AND PROGRAMS, UTILIZATION REVIEW PPOLICIES AND PROGRAMS, RECORD KEEPING, AND STAFF EDUCATION.

The applicant so verifies.

C(III).6. DISCUSS YOUR HEALTH CARE INSTITUTION'S PARTICIPATION IN THE TRAINING OF STUDENTS IN THE AREAS OF MEDICINE, NURSING, SOCIAL WORK, ETC. (I.E., INTERNSHIPS, RESIDENCIES, ETC.).

C(III).7(a). PLEASE VERIFY, AS APPLICABLE, THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSURE REQUIREMENTS OF THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, THE DIVISION OF MENTAL RETARDATION SERVICES, AND/OR ANY APPLICABLE MEDICARE REQUIREMENTS.

The applicant so verifies.

C(III).7(b). PROVIDE THE NAME OF THE ENTITY FROM WHICH THE APPLICANT HAS RECEIVED OR WILL RECEIVE LICENSURE, CERTIFICATION, AND/OR ACCREDITATION

LICENSURE:	Board for Licensure of Healthcare Facilities Tennessee Department of Health
CERTIFICATION:	Medicare Certification from CMS TennCare Certification from TDH and Georgia
ACCREDITATION:	Accreditation Association for Ambulatory Healthcare (AAAHC)

C(III).7(c). IF AN EXISTING INSTITUTION, PLEASE DESCRIBE THE CURRENT STANDING WITH ANY LICENSING, CERTIFYING, OR ACCREDITING AGENCY OR AGENCY.

The applicant is currently licensed in good standing by the Board for Licensing Health Care Facilities, is certified for participation in Medicare and Tennessee and Georgia Medicaid/TennCare, and is fully accredited by the Accreditation Association for Ambulatory Healthcare (AAAHC).

C(III).7(d). FOR EXISTING LICENSED PROVIDERS, DOCUMENT THAT ALL DEFICIENCIES (IF ANY) CITED IN THE LAST LICENSURE CERTIFICATION AND INSPECTION HAVE BEEN ADDRESSED THROUGH AN APPROVED PLAN OF CORRECTION. PLEASE INCLUDE A COPY OF THE MOST RECENT LICENSURE/CERTIFICATION INSPECTION WITH AN APPROVED PLAN OF CORRECTION.

They have been addressed. A copy of the most recent licensure inspection and plan of correction, and/or the most recent accreditation inspection, are provided in Attachment C, Orderly Development--7(C).

C(III)8. DOCUMENT AND EXPLAIN ANY FINAL ORDERS OR JUDGMENTS ENTERED IN ANY STATE OR COUNTRY BY A LICENSING AGENCY OR COURT AGAINST PROFESSIONAL LICENSES HELD BY THE APPLICANT OR ANY ENTITIES OR PERSONS WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE APPLICANT. SUCH INFORMATION IS TO BE PROVIDED FOR LICENSES REGARDLESS OF WHETHER SUCH LICENSE IS CURRENTLY HELD.

None.

C(III)9. IDENTIFY AND EXPLAIN ANY FINAL CIVIL OR CRIMINAL JUDGMENTS FOR FRAUD OR THEFT AGAINST ANY PERSON OR ENTITY WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE PROJECT.

None.

C(III)10. IF THE PROPOSAL IS APPROVED, PLEASE DISCUSS WHETHER THE APPLICANT WILL PROVIDE THE THSDA AND/OR THE REVIEWING AGENCY INFORMATION CONCERNING THE NUMBER OF PATIENTS TREATED, THE NUMBER AND TYPE OF PROCEDURES PERFORMED, AND OTHER DATA AS REQUIRED.

Yes. The applicant will provide the requested data consistent with Federal HIPAA requirements.

PROOF OF PUBLICATION

Attached.

DEVELOPMENT SCHEDULE

1. PLEASE COMPLETE THE PROJECT COMPLETION FORECAST CHART ON THE NEXT PAGE. IF THE PROJECT WILL BE COMPLETED IN MULTIPLE PHASES, PLEASE IDENTIFY THE ANTICIPATED COMPLETION DATE FOR EACH PHASE.

The Project Completion Forecast Chart is provided after this page.

2. IF THE RESPONSE TO THE PRECEDING QUESTION INDICATES THAT THE APPLICANT DOES NOT ANTICIPATE COMPLETING THE PROJECT WITHIN THE PERIOD OF VALIDITY AS DEFINED IN THE PRECEDING PARAGRAPH, PLEASE STATE BELOW ANY REQUEST FOR AN EXTENDED SCHEDULE AND DOCUMENT THE "GOOD CAUSE" FOR SUCH AN EXTENSION.

Not applicable. The applicant anticipates completing the project within the period of validity.

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c):

September 23, 2015

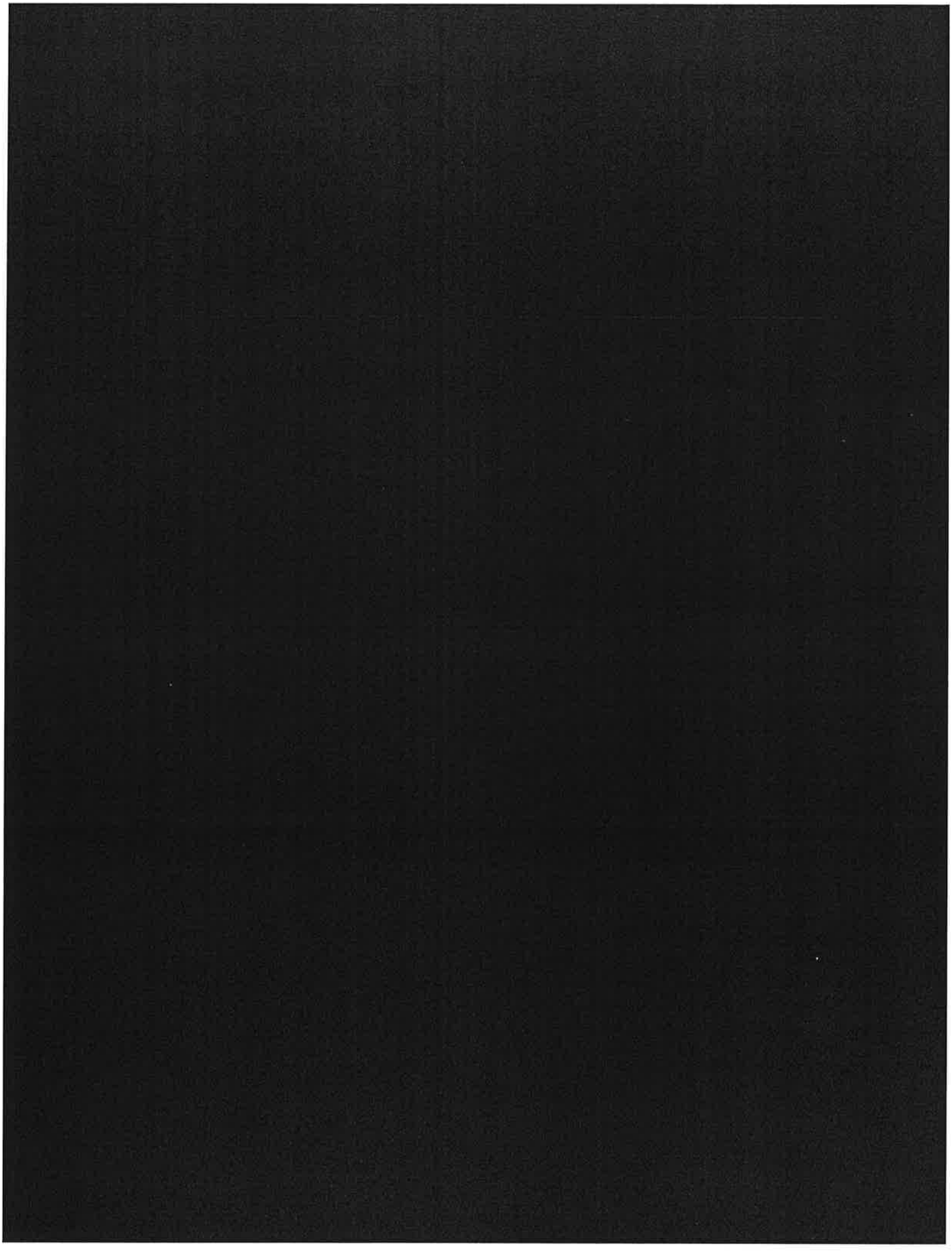
Assuming the CON decision becomes the final Agency action on that date, indicate the number of days from the above agency decision date to each phase of the completion forecast.

PHASE	DAYS REQUIRED	Anticipated Date (MONTH /YEAR)
1. Architectural & engineering contract signed	7	10-1-15
2. Construction documents approved by TDH	72	12-15-15
3. Construction contract signed	88	12-30-15
4. Building permit secured	91	1-2-16
5. Site preparation completed	na	na
6. Building construction commenced	149	3-1-16
7. Construction 40% complete	272	6-30-16
8. Construction 80% complete	232	8-30-16
9. Construction 100% complete	423	12-1-16
10. * Issuance of license	437	12-15-16
11. *Initiation of service	467	1-1-17
12. Final architectural certification of payment	528	3-1-17
13. Final Project Report Form (HF0055)	588	5-1-17

*** For projects that do NOT involve construction or renovation: please complete items 10-11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

INDEX OF ATTACHMENTS



INDEX OF ATTACHMENTS

A.4--Ownership
Legal Entity and Organization Chart

Board for Licensing Health Care Facilities

State of Tennessee

License No. 0000000098

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

THE CHATTANOOGA ENDOSCOPY ASC,LLC *to conduct and maintain*

an Ambulatory Surgical Treatment Center DIGESTIVE DISORDERS ENDOSCOPY CENTER

Located at 2341 MCCALLIE AVENUE, PARKRIDGE PLAZA III, STE. 303 , CHATTANOOGA

County of HAMILTON *, Tennessee.*

This license shall expire JUNE 18 , 2016 , *and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 26TH *day of* MAY , 2015 .

In the Specialty(ies) of: GASTROENTEROLOGY

By Vincent J. Dario, MPH

DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By

COMMISSIONER

Board for Licensing Health Care Facilities

State of Tennessee

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In Witness Whereof, we have hereunto set our hand and seal of the State this 18TH *day of* JUNE , 2014 .

In the Speciality(ies) of: GASTROENTEROLOGY

By Vincent J. Dario, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By
COMMISSIONER

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

March 11, 2015

Organization #:	**83973**
Organization:	**The Chattanooga Endoscopy ASC, LLC dba Digestive Disorder Endoscopy Center**
Address:	**2341 Mccallie Ave, Parkridge Plaza Iii**
City, State, Zip:	**Chattanooga, TN 37404-3239**
Decision Recipient:	**Kristi Ballard, RN**
Survey Date:	**February 10, 2015**

Type of Survey: **Re-Accreditation**

Accreditation Term Begins: **March 13, 2015** **Accreditation Term Expires:** **March 12, 2018**

Accreditation Renewal Code: **9557d42183973**
Complimentary study participation code: **83973FREEIQI**

Granting accreditation reflects confidence, based on evidence from this recent survey that you meet, and will continue to demonstrate throughout the accreditation term, the attributes of an accreditable organization, as reflected in the standards found in the *Accreditation Handbook for Ambulatory Health Care*. The dedication and effort necessary for an organization to be accredited is substantial and the compliance with those standards implies a commitment to continual self-evaluation and continuous improvement.

We hope the survey has been beneficial to your organization in identifying its strengths and opportunities to improve. AAAHC trusts that you will continue to find the accreditation experience meaningful, not only from the benefit of having carefully reviewed your own operation, but also from the recognition brought by your participation in this survey process.

Members of your organization should take time to review your Survey Report, which may arrive separately:

- Any standard marked "PC" (Partially Compliant) or "NC" (Non-Compliant) must be corrected promptly. Subsequent surveys by the AAAHC will seek evidence that deficiencies from this survey were addressed without delay.
- The Summary Table provides an overview of compliance for each chapter applicable to the organization.
- Statements in the "Consultative Comments" sections of the report represent the educational component of the survey. Such comments may provide helpful guidance for improvement.
- As a guide to the ongoing process of self-evaluation, periodic review of the Survey Report and the current year's *Handbook* will ensure the organization's ongoing compliance with the standards throughout the term of accreditation.

AAAHC policies and procedures and standards are revised on an annual basis, such revisions become effective March 1 each year. Accredited organizations are required to maintain their operations in compliance with the current AAAHC standards and policies. Therefore, the organization is encouraged to visit the AAAHC website, www.aaahc.org, for information pertaining to any revisions to AAAHC policies and procedures and standards.

In order to ensure continuation of accreditation, your organization should submit an application for survey approximately five months prior to your accreditation expiration. According to our *Accreditation Handbook*,

Currently-accredited organizations must complete and submit the Application for Survey, supporting documentation, and application fee for their subsequent full accreditation survey (referred to as a re-accreditation survey). Please visit www.aaahc.org to complete the Application for Survey and for further information. After review of an organization's completed Application for Survey and supporting documentation, the AAAHC will contact the organization to establish survey dates. To prevent a lapse in accreditation, an organization should ensure that all documentation is submitted to the AAAHC at least five (5) months prior to its accreditation expiration date. In states where accreditation is mandated by law, an organization should submit the completed Application for Survey and other required documentation a minimum of six (6) months prior to its accreditation expiration date.

For submission of an application for survey, your organization will need the "*accreditation renewal code*" located underneath the accreditation expiration date.

You will notice that you have a "*complimentary study participation code*" at the top of this letter. You may use this to register for one of the AAAHC Institute for Quality Improvement's studies. Please visit www.aaahc.org/institute for additional information or contact Michelle Chappell, at 847-324-7747 or mchappell@aaahc.org.

If you have any questions or comments about any portion of the accreditation process, please contact the AAAHC Accreditation Services department at (847) 853-6060.

Owners of the Applicant (All Physicians are Credentialed Members of the Medical Staff)

Ownership of The Chattanooga Endoscopy ASC, LLC		
Owner's Names	**Address**	**Membership (%)**
AmSurg Holdings, Inc.	1A Burton Hills Blvd Nashville, TN 37215	35.000%
1. Sumeet Bhushan, MD	2200 East Third Street, Ste 200 Chattanooga, TN 37404	5.416%
2. Chad Charapta, MD	2201 East Third Street, Ste 200 Chattanooga, TN 37404	5.416%
3. David N. Collins, MD	721 Glenwood Drive, Ste E690 Chattanooga, TN 37404	5.416%
4. Donald Hetzel, MD	2515 DeSales Avenue, Ste 206 Chattanooga, TN 37404	5.416%
5. Scott Manton, MD	2515 DeSales Avenue, Ste 206 Chattanooga, TN 37404	5.416%
6. Gregory Olds, MD	2205 East Third Street, Ste 200 Chattanooga, TN 37404	5.416%
7. Henry Paik, MD	2341 McCallie Avenue, Ste 402 Chattanooga, TN 37404	5.417%
8. Vijay Patel, MD	2515 DeSales Avenue, Ste 206 Chattanooga, TN 37404	5.416%
9.Chattanoga Gastroenterology, PC (Richard Sadowitz, MD)	2341 McCallie Avenue, Ste 400 Chattanooga, TN 37404	5.417%
10. Colleen Schmitt, MD	2209 East Third Street, Ste 200 Chattanooga, TN 37404	5.416%
11. Alan Shikoh, MD	721 Glenwood Drive, Ste W473 Chattanooga, TN 37404	5.416%
12. Larry Shuster, MD	2211 East Third Street, Ste 200 Chattanooga, TN 37404	5.416%

Source: AmSurg

Additional Medical Staff Who Are Not Owners:

13. Munford Yates, MD
14. Camille Somer, MD
15. Richard Krause, MD

Print Form

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR CHANGE OR CANCELLATION OF ASSUMED LIMITED LIABILITY COMPANY NAME

For Office Use Only

FILED

Pursuant to the provisions of §48-207-101(e) of the Tennessee Limited Liability Company Act or §48-249-106(e) of the Tennessee Revised Limited Liability Company Act, the undersigned Limited Liability Company hereby submits this application:

1. The true name of the Limited Liability Company is: The Chattanooga Endoscopy ASC, LLC

2. The state or country of formation is: Tennessee

3. The Limited Liability Company intends to cease transacting business under an assumed Limited Liability Company name by changing or cancelling it;

4. The assumed Limited Liability Company name to be changed from or cancelled is: Digestive Disorders Endoscopy Center

5. If the assumed name is to be changed, the assumed LLC name which the LLC proposes to use is:

Chattanooga Endoscopy Center

5/13/15
Signature Date

The Chattanooga Endoscopy ASC, LLC
Name of Limited Liability Company

Vice President
Signer's Capacity

Signature

Clint Cromwell
Name (typed or printed)

SS-4229 (Rev. 01/06)

RDA 2458

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

THE CHATTANOOGA ENDOSCOPY ASC, LLC
1A BURTON HILLS BLVD
NASHVILLE, TN 37215-6187

May 20, 2015

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

Control # : 374759 Status: Active
Filing Type: Limited Liability Company - Domestic

Document Receipt

Receipt # : 002064490	Filing Fee:	$20.00
Payment-Check/MO - CHATTANOOGA ENDOSCOPY ASC, LLC, NASHVILLE, TN		$20.00

Amendment Type: Assumed Name Change
Filed Date: 05/20/2015 9:38 AM
Image # : B0104-0346

This will acknowledge the filing of the attached assumed name change with an effective date as indicated above. When corresponding with this office or submitting documents for filing, please refer to the control number given above. The name registration is effective for five years from the date the original registration was filed with the Secretary of State.

Tre Hargett
Secretary of State

Processed By: Carol Dickerson

Field Name	Changed From	Changed To
Assumed Name Cancelled	No Value	DIGESTIVE DISORDERS ENDOSCOPY CENTER
New Assumed Name	No Value	Chattanooga Endoscopy Center

Tennessee Secretary of State
Tre Hargett

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Business Entity Detail

Available Entity Actions
- File Annual Report (after 12/01/2015)
- Certificate of Existence
- More

Entity details cannot be edited. This detail reflects the current state of the filing in the system.

Return to the Business Information Search.

000374759: Limited Liability Company - Domestic Printer Friendly Version

Name: THE CHATTANOOGA ENDOSCOPY ASC, LLC

Status: Active
Formed in: TENNESSEE
Fiscal Year Close: December
Term of Duration: Perpetual
Principal Office: 1A BURTON HILLS BLVD NASHVILLE, TN 37215-6187 USA
Mailing Address: 1A BURTON HILLS BLVD NASHVILLE, TN 37215-6187 USA
AR Exempt: No
Managed By: Board Managed

Initial Filing Date: 07/29/1999
Delayed Effective Date:
AR Due Date: 04/01/2016
Inactive Date:
Obligated Member Entity: No
Number of Members: 3

Assumed Names | History | Registered Agent

Name	Status	Expires
DIGESTIVE DISORDERS ENDOSCOPY CENTER	Inactive - Name Changed	06/30/2019
Chattanooga Endoscopy Center	Active	05/20/2020

Division of Business Services
312 Rosa L. Parks Avenue, Snodgrass Tower, 6th Floor
Nashville, TN 37243
615-741-2286
Email | Directions | Hours and Holidays | Methods of Payment

Business Filings and Information (615) 741-2286 | TNSOS.CORPINFO@tn.gov
Certified Copies and Certificate of Existence (615) 741-6488 | TNSOS.CERT@tn.gov
Motor Vehicle Temporary Liens (615) 741-0529 | TNSOS.MVTL@tn.gov
Uniform Commercial Code (UCC) (615) 741-3276 | TNSOS.UCC@tn.gov
Workers' Compensation Exemption Registrations (615) 741-0526 | TNSOS.WCER@tn.gov
Apostilles & Authentications (615) 741-0536 | TNSOS.ATS@tn.gov
Summons (615) 741-1799 | TNSOS.ATS@tn.gov
Trademarks (615) 741-0531 | TNSOS.ATS@tn.gov

Tennessee Secretary of State
Tre Hargett

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Business Services Online > Find and Update a Business Record

Business Information Search

If you are processing multiple annual reports, please allow at least two minutes between payment transactions to avoid errors. As of May 13, 2015 we have processed all corporate filings received in our office through May 12, 2015 and all annual reports received in our office through May 12, 2015.

Click on the underlined control number of the entity in the search results list to proceed to the detail page. From the detail page you can verify the entity displayed is correct (review addresses and business details) and select from the available entity actions - file an annual report, obtain a certificate of existence, file an amendment, etc.

Search: 1-1 of 1

Search Name: The Chattanooga Endoscopy ASC, LLC ○ Starts With ○ Contains

Control #:

Active Entities Only: ☐

Search

Control #	Entity Type	Name	Name Type	Name Status	Entity Filing Date	Entity Status
000374759	LLC	THE CHATTANOOGA ENDOSCOPY ASC, LLC *TENNESSEE*	Entity	Active	07/29/1999	Active

1-1 of 1

Information about individual business entities can be queried, viewed and printed using this search tool for free.

If you want to get an electronic file of all business entities in the database, the full database can be downloaded for a fee by Clicking Here.

Click Here for information on the Business Services Online Search logic.

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Business Information Search

If you are processing multiple annual reports, please allow at least two minutes between payment transactions to avoid errors. As of May 13, 2015 we have processed all corporate filings received in our office through May 12, 2015 and all annual reports received in our office through May 12, 2015.

Click on the underlined control number of the entity in the search results list to proceed to the detail page. From the detail page you can verify the entity displayed is correct (review addresses and business details) and select from the available entity actions - file an annual report, obtain a certificate of existence, file an amendment, etc.

Search: 1-2 of 2

Search Name: AmSurg Holdings ○ Starts With ○ Contains

Control #:

Active Entities Only: ○

Search

Control #	Entity Type	Name	Name Type	Name Status	Entity Filing Date	Entity Status
000291010	CORP	AMSURG HOLDINGS, INC. *TENNESSEE*	Entity	Inactive	02/23/1995	Inactive - Merged
000765122	CORP	AmSurg Holdings, Inc. *DELAWARE*	Entity	Active	07/18/2014	Active

1-2 of 2

Information about individual business entities can be queried, viewed and printed using this search tool for free.

If you want to get an electronic file of all business entities in the database, the full database can be downloaded for a fee by Clicking Here.

Click Here for information on the Business Services Online Search logic.

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Motor Vehicle Temporary Liens (615) 741-0529 | TNSOS.MVTL@tn.gov
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Summons (615) 741-1799 | TNSOS.ATS@tn.gov
Trademarks (615) 741-0531 | TNSOS.ATS@tn.gov

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LINKS

Tennessee General Assembly
Bureau of Ethics and Campaign Finance
Tennessee Code Unannotated

Secretary of State
Corporations Section
James K. Polk Building, Suite 1800
Nashville, Tennessee 37243-0306

DATE: 07/29/99
REQUEST NUMBER: 3717-1501
TELEPHONE CONTACT: (615) 741-2286
FILE DATE/TIME: 07/29/99 1134
EFFECTIVE DATE/TIME: 07/29/99 1134
CONTROL NUMBER: 0374759

TO:
THE CHATTANOOGA ENDOSCOPY ASC,LLC
ONE BURTON HILLS BLV
SUITE 350
NASHVILLE, TN 37215

RE:
THE CHATTANOOGA ENDOSCOPY ASC, LLC
ARTICLES OF ORGANIZATION -
LIMITED LIABILITY COMPANY

CONGRATULATIONS UPON THE FORMATION OF THE LIMITED LIABILITY COMPANY IN THE STATE OF TENNESSEE WHICH IS EFFECTIVE AS INDICATED ABOVE.

A LIMITED LIABILITY COMPANY ANNUAL REPORT MUST BE FILED WITH THE SECRETARY OF STATE ON OR BEFORE THE FIRST DAY OF THE FOURTH MONTH FOLLOWING THE CLOSE OF THE LIMITED LIABILITY COMPANY'S FISCAL YEAR. ONCE THE FISCAL YEAR HAS BEEN ESTABLISHED, PLEASE PROVIDE THIS OFFICE WITH WRITTEN NOTIFICATION. THIS OFFICE WILL MAIL THE REPORT DURING THE LAST MONTH OF SAID FISCAL YEAR TO THE LIMITED LIABILITY COMPANY AT THE ADDRESS OF ITS PRINCIPAL OFFICE OR TO A MAILING ADDRESS PROVIDED TO THIS OFFICE IN WRITING. FAILURE TO FILE THIS REPORT OR TO MAINTAIN A REGISTERED AGENT AND OFFICE WILL SUBJECT THE LIMITED LIABILITY COMPANY TO ADMINISTRATIVE DISSOLUTION.

WHEN CORRESPONDING WITH THIS OFFICE OR SUBMITTING DOCUMENTS FOR FILING, PLEASE REFER TO THE LIMITED LIABILITY COMPANY CONTROL NUMBER GIVEN ABOVE. PLEASE BE ADVISED THAT THIS DOCUMENT MUST ALSO BE FILED IN THE OFFICE OF THE REGISTER OF DEEDS IN THE COUNTY WHEREIN A LIMITED LIABILITY COMPANY HAS ITS PRINCIPAL OFFICE IF SUCH PRINCIPAL OFFICE IS IN TENNESSEE.

FOR: ARTICLES OF ORGANIZATION -
LIMITED LIABILITY COMPANY

ON DATE: 07/29/99

FROM:
CAPITAL FILING SERVICE, INC.
7051 HWY 70 S
#333
NASHVILLE, TN 37221-0000

	FEES	
RECEIVED:	$300.00	$0.00

TOTAL PAYMENT RECEIVED: $300.00

RECEIPT NUMBER: 00002529197
ACCOUNT NUMBER: 00101230

Riley C Darnell

RILEY C. DARNELL
SECRETARY OF STATE

SS-4458

FILED

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SECRETARY OF STATE
99 JUL 29 AM

ARTICLES OF ORGANIZATION
OF
THE CHATTANOOGA ENDOSCOPY ASC, LLC

FILED
SECRETARY OF STATE

The undersigned, acting as the organizer of a limited liability company under the Tennessee Limited Liability Company Act, Tennessee Code Annotated, Section 48-201-101 et seq. (the "Act"), hereby adopts the following Articles of Organization for such limited liability company:

ARTICLE I.

The name of the limited liability company is The Chattanooga Endoscopy ASC, LLC.

ARTICLE II.

The street address and zip code of the initial registered office of the limited liability company shall be One Burton Hills Boulevard, Suite 350, Nashville, Davidson County, Tennessee 37215. The name of the limited liability company's initial registered agent at its initial registered office is Claire M. Gulmi.

ARTICLE III.

The name and address of the organizer is Randall E. Bruce, Bass, Berry & Sims PLC, 2700 First American Center, Nashville, Tennessee 37238-2700.

ARTICLE IV.

At the effective date and time of formation and filing, there are two (2) members of the limited liability company.

ARTICLE V.

The limited liability company shall be managed by a board of governors.

ARTICLE VI.

The street address and zip code of the principal executive office of the limited liability company and the county in which the principal executive office is located is One Burton Hills Boulevard, Suite 350, Nashville, Davidson County, Tennessee 37215.

ARTICLE VII.

The members of the limited liability company and any other parties to any contribution agreement or contribution allowance agreement with the limited liability company shall not have preemptive rights.

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SECRETARY OF STATE

ARTICLE VIII

A member may, without the consent of any other member, assign governance rights to another person already a member at the time of the assignment. Any other assignment of any governance rights is effective only if the assignment is approved by all of the remaining members.

ARTICLE IX.

To the fullest extent permitted by the Act, as in effect on the date hereof and as hereafter amended from time to time, a governor shall not be liable to the limited liability company or its members for monetary damages for breach of fiduciary duty as a governor. If the Act or any successor statute is amended after adoption of this provision to authorize limited liability company action further eliminating or limiting the personal liability of governors, then the liability of a governor shall be eliminated or limited to the fullest extent permitted by the Act, as so amended from time to time. Any repeal or modification of this Article IX by the members of the limited liability company shall not adversely affect any right or protection of a governor of the limited liability company existing at the time of such repeal or modification or with respect to events occurring prior to such time.

ARTICLE X.

The limited liability company shall not have the power to expel a member.

ARTICLE XI.

The limited liability company shall indemnify and advance expenses to any responsible person, manager, employee or agent made a party to a proceeding to the fullest extent permitted by the Act and applicable law, as in effect on the date hereof and as hereafter amended from time to time.

ARTICLE XII.

The board may appoint or otherwise designate managers other than the chief manager and secretary. Such designated managers shall have such authority and shall perform the duties as the board may from time to time prescribe.

IN WITNESS WHEREOF, these Articles of Organization have been executed on this 29 day of July, 1999 by the undersigned organizer of the limited liability company.

Randall E. Bruce

Randall E. Bruce, Organizer

2014031.1

Arizona Ophthalmic Outpatient Surgery

Address: 300 East Osborn Road
Suite 102
Phoenix, AZ 85012-2383

Directions to Center

Phone: 602-234-8478

Website:

Arkansas Valley Surgery Center

Address: 933 Sells Avenue
Canon City, CO 81212-4900

Appointment
Directions to Center

Phone: 719-275-6433

Website: **http://www.arkansasvalleysurgerycenter.com**

Associated Endoscopy, L.L.C.

Address: 5653 Frist Boulevard
Suite 532
Hermitage, TN 37076-2067

Appointment
Directions to Center

Phone: 615-316-3066

Website: **http://www.associatedendoscopy.com**

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Central Florida Surgical Center

Address: 11140 West Colonial Drive
Suite 3
Ocoee, FL 34761-3300

Phone: 407-656-2700

Website: http://www.centralfloridagicenters.com

Appointment
Directions to Center

Central Texas Endoscopy Center

Address: 2206 East Villa Maria Drive
Bryan, TX 77802-2547

Phone: 979-774-4211

Website: http://www.centraltexasendoscopy.com

Appointment
Directions to Center

Chevy Chase Endoscopy Center

Address: 5530 Wisconsin Avenue
Suite 500
Chevy Chase, MD 20815-4467

Phone: 301-654-8020

Website: http://www.ccendo.com

Appointment
Directions to Center

Citrus Ambulatory Surgery Center

Address: 2861 South Delaney Avenue
Suite B
Orlando, FL 32806-5409

Phone: 407-472-5095

Website: http://www.centralfloridagicenters.com

Appointment
Directions to Center

Citrus Endoscopy and Surgery Center

Address: 6412 West Gulf to Lake Highway
Crystal River, FL 34429-7622

Phone: 352-563-0223

Website:

Directions to Center

College Heights Endoscopy Center

Address: 3147 College Heights Boulevard
Allentown, PA 18104-4813

Phone: 610-841-2432

Website:

Directions to Center

Columbia Gastrointestinal Endoscopy Center

Address: 2739 Laurel Street
Suite 1B
Columbia, SC 29204-2028

Phone: 803-254-9588

Website: http://www.columbiagicenters.com

Appointment
Directions to Center

Columbus Eye Surgery Center

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Coral Springs Surgical Center

Address: 1725 North University Drive
2nd Floor
Coral Springs, FL 33071-6053

Phone: 954-227-7760

Website:

Directions to Center

Davis Surgery Center

Address: 2120 Cowell Boulevard
Suite 142
Davis, CA 95618-7840

Phone: 530-750-7766

Website:

Directions to Center

Des Peres Square Surgery Center

Address: 1050 Old Des Peres Road
Suite 150
St Louis, MO 63131-1874

Phone: 314-569-2918

Website:

Directions to Center

Diagnostic Endoscopy Center

Address: 778 Long Ridge Road
Suite 2
Stamford, CT 06902-1265

Phone: 203-322-2400

Website:

Directions to Center

Digestive Disorders Endoscopy Center

CEC

Address: 2341 McCallie Avenue
Suite 303
Chattanooga, TN 37404-3237

Phone: 423-698-3999

Website: http://www.chattanoogaddec.com

Appointment
Directions to Center

Digestive Endoscopy Center - Brubaker

Address: 999 Brubaker Drive
Suite 3
Kettering, OH 45429-3556

Phone: 937-534-7330

Website:

Directions to Center

Digestive Endoscopy Center - Huber Heights

Address: 7415 Brandt Pike
Huber Heights, OH 45424-3239

Phone: 937-534-7330

Website:

Directions to Center

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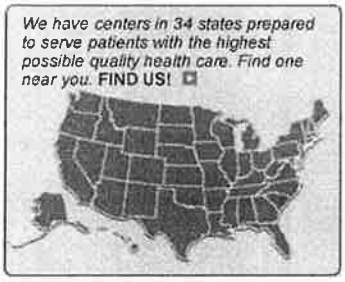

Our Centers

Endoscopy Center of the Central Coast

Address: 77 Casa Street
Suite 106
San Luis Obispo, CA 93405-5804

Phone: 805-541-1021

Website: http://www.centralcoastendoscopycenters.com

Appointment
Directions to Center

Endoscopy Center of the South Bay

Address: 23560 Madison Street
Suite 109
Torrance, CA 90505-4709

Phone: 310-325-6331

Website: http://www.surgerycentersouthbay.com

Appointment
Directions to Center

Endoscopy Center of the Upstate

Address: 14 Hawthorne Park Court
Greenville, SC 29615-3194

Phone: 864-331-0364

Website: http://www.endocenterupstate.com

Appointment
Directions to Center

Endoscopy Center of Yuma

Address: 1030 West 24th Street
Suite I
Yuma, AZ 85364-8384

Phone: 928-343-1717

Website: http://www.endoscopycenteryuma.com

Appointment
Directions to Center

Eye Institute at Boswell

Address: 10541 West Thunderbird Boulevard
Sun City, AZ 85351-3006

Phone: 623-933-3402

Website: http://www.eyeinstituteboswell.com

Appointment
Directions to Center

Eye Surgery and Laser Center of Sebring

Address: 5030 US Highway 27 North
Sebring, FL 33870-1354

Phone: 863-385-1074

Website:

Directions to Center

Eye Surgery and Laser Center, LLC

Address: 409 Avenue K, Southeast
Winter Haven, FL 33880-4126

Phone: 863-294-3504

Website:

Directions to Center

Eye Surgery Center of East Tennessee

Address: 1124 Weisgarber Road

Appointment

Address: 1120 Weisgarber Rd
Suite 110
Knoxville, TN 37909-2600

Directions to Center

Phone: 865-588-1037

Website: http://www.eyesurgerycenteretn.com

Eye Surgery Center of Tulsa

Address: 7191 South Yale Avenue
Tulsa, OK 74136-6326

Appointment
Directions to Center

Phone: 918-524-1600

Website: http://www.eyesurgerycenteroftulsa.com

EyeCare Consultants Surgery Center

Address: 101 NW First Street
Suite 104, Old Post Office Place
Evansville, IN 47708-1220

Directions to Center

Phone: 812-435-2372

Website:

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Mid Florida Surgery Center

Address: 17564 U.S. Highway 441
Mount Dora, FL 32757-6711

Phone: 352-735-4100

Website:

Directions to Center

Mid-Atlantic Endoscopy Center

Address: 4923 Ogletown-Stanton Rd.
Newark, DE 19713-2081

Phone: 302-993-0310

Website:

Directions to Center

Middlesex Endoscopy Center

Address: 45 A Discovery Way
Acton, MA 01720-4482

Phone: 978-429-2000

Website: www.middlesexdigestive.com/

Appointment
Directions to Center

Mid-South Endoscopy Center

Address: 1510 1/2 Hatcher Lane
Columbia, TN 38401-4825

Phone: 931-381-7818

Website: http://www.midsouthendocenter.com

Appointment
Directions to Center

Minneapolis Eye Center

Address: 8401 Golden Valley Road
Suite 340
Golden Valley, MN 55427-4488

Phone: 763-383-4150

Website: http://www.mplseye.com

Appointment
Directions to Center

Mission Valley Heights Surgery Center

Address: 7485 Mission Valley Road
Suite 106
San Diego, CA 92108-4407

Phone: 619-291-3737

Website: http://www.mvhsc.com

Appointment
Directions to Center

North Hills Gastroenterology Endoscopy Center

Address: 3344 North Futrall Drive
Suite 3
Fayetteville, AR 72703-4057

Phone: 479-582-7280

Website: http://www.northhillsendoscopy.com

Appointment
Directions to Center

North Metro Surgery Center

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St Cloud Center for Ophthalmic Surgery

Address: 2055 North 15th Street
Suite B
St. Cloud, MN 56303-1543

Phone: 320-258-6620

Website: http://www.stcloudeyesurgery.com

Appointment
Directions to Center

St. George Endoscopy Center

Address: 368 East Riverside Drive
Suite B
St. George, UT 84790-6898

Phone: 435-674-3109

Website:

Directions to Center

St. Thomas Medical Group Endoscopy Center

Address: 4230 Harding Road
Suite 400
Nashville, TN 37205-4900

Phone: 615-250-4108

Website: http://www.stmgendo.com

Appointment
Directions to Center

Sterling Surgery Center

Address: 1441 Wilkins Circle
Casper, WY 82601-1337

Phone: 307-265-1792

Website:

Directions to Center

Summit Surgical Center

Address: 1630 East Herndon Avenue
Suite 100
Fresno, CA 93720-3391

Phone: 559-449-2888

Website:

Directions to Center

Sun City Endoscopy Center

Address: 13203 North 103 Avenue
Suite C3
Sun City, AZ 85351-3028

Phone: 623-972-5083

Website:

Directions to Center

Sun City West Ambulatory Surgery Center

Address: 14416 West Meeker Boulevard
Suite 103
Sun City, AZ 85375-5284

Phone: 623-583-5280

Website:

Directions to Center

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Our Centers

Team Vision Surgery Center

Address: 6100 East Central Avenue
Suite 5
Wichita, KS 67208-4237

Directions to Center

Phone: 316-681-2020

Website:

Temecula Valley Endoscopy Center

Address: 25150 Hancock Avenue
Suite 208
Murrieta, CA 92562-5989

Appointment
Directions to Center

Phone: 951-698-8805

Website: http://gidocs4u.com/

Templeton Endoscopy Center

Address: 1320 Las Tablas
Suite A
Templeton, CA 93465-9711

Appointment
Directions to Center

Phone: 805-434-9950

Website: http://www.centralcoastendoscopycenters.com

Tennessee Endoscopy Center

Address: 1706 East Lamar Alexander Parkway
Maryville, TN 37804-6204

Appointment
Directions to Center

Phone: 865-983-0073

Website: http://www.tennesseeendo.com

Texas GI Endoscopy Center

Address: 2704 North Galloway Avenue
Suite 102
Mesquite, TX 75150-6378

Appointment
Directions to Center

Phone: 972-270-3590

Website: http://www.texasgicenter.com

The Blue Hen Surgery Center

Address: 655 Bay Road
Suite 5B
Dover, DE 19901-4660

Appointment
Directions to Center

Phone: 302-678-4688

Website: http://www.bluehensurgerycenter.com

The Center for Ambulatory Surgery

Address: 1450 Route 22 West
Mountainside, NJ 07092-2619

Appointment
Directions to Center

Phone: 908-233-2020

Website: http://www.tcfas.net/

The Endo Center at Voorhees

Address: 93 Cooper Road
Suite 100
Voorhees, NJ 08043

Directions to Center

Phone: 856-770-1920

Website:

The Endoscopy and Surgery Center of Topeka

Address: 2200 Southwest 6th Street
Suite 103
Topeka, KS 66606-1707

Appointment
Directions to Center

Phone: 785-354-1254

Website: http://www.topekaendocenter.com

The Endoscopy Center

Address: 801 Weisgarber Road
Suite 100
Knoxville, TN 37909-2707

Appointment
Directions to Center

Phone: 865-588-5121

Website: http://www.knoxvilleendocenter.com

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Existing Partners

AMSURG

Our Centers

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Where We Are

Board Certification

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---Select---

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We have centers in 34 states prepared to serve patients with the highest possible quality health care. Find one near you. FIND US!

Our Centers

The Endoscopy Center - East

Address: 3800 South Whitney
Suite 100
Independence, MO 64055-6739

Directions to Center

Phone: 816-478-4887

Website:

The Endoscopy Center - Liberty

Address: 9601 Northeast 79th Street
Kansas City, MO 64158-1117

Directions to Center

Phone: 816-478-4887

Website:

The Endoscopy Center - North

Address: 5330 North Oak Trafficway
Suite 100
Kansas City, MO 64118-4625

Directions to Center

Phone: 816-478-4887

Website:

The Endoscopy Center - West

Address: 11440 Parkside Drive
Suite 100
Knoxville, TN 37934-2658

Appointment
Directions to Center

Phone: 865-588-5121

Website: http://www.knoxvilleendocenter.com

The Endoscopy Center at Meridian

Address: 13313 North Meridian
Building B
Oklahoma City, OK 73120-8316

Appointment
Directions to Center

Phone: 405-755-4140

Website: http://www.tecameridian.com

The Endoscopy Center North

Address: 629 Delozier Way
Powell, TN 37849-4030

Directions to Center

Phone: 865-588-5121

Website:

The Endoscopy Center of Santa Fe

Address: 1630 Hospital Drive
Santa Fe, NM 87505-4773

Directions to Center

Phone: 505-988-3373

Website:

The Endoscopy Center of Washington, D.C.

A.5--Management Contract

AMENDED AND RESTATED MANAGEMENT SERVICES AGREEMENT

This Amended and Restated Management Services Agreement (the "Agreement") is entered into effective this 1st day of February, 2015 (the "Effective Date") by and between The Chattanooga Endoscopy ASC, LLC, a Tennessee limited liability company ("LLC") and AmSurg Corp., a Tennessee corporation ("AmSurg").

WHEREAS, the LLC owns and operates an ambulatory surgery center in Chattanooga, Tennessee (the "Center"); and

WHEREAS, AmSurg and the LLC are parties to that certain Management Services Agreement, effective as of February 1, 2001 (the "2001 Management Agreement"); and

WHEREAS, the LLC and AmSurg desire to amend and restate the 2001 Management Agreement in its entirety by entering into this Agreement.

NOW THEREFORE, in consideration of the premises and the mutual promises and covenants contained herein, the LLC and AmSurg do hereby agree as follows:

1. ENGAGEMENT

The LLC engages the services of AmSurg, and AmSurg agrees to provide such services upon the terms and conditions hereinafter set forth.

2. NATURE OF RELATIONSHIP

AmSurg shall perform all services described in Section 3 hereof, for the account of and as agent of the LLC. Except as otherwise specifically provided in Section 4, AmSurg shall bear the costs and expenses of all services provided by AmSurg pursuant to this Agreement.

The LLC hereby appoints AmSurg its attorney-in-fact with full power on its behalf and in its name, or in the name of the Center, to prosecute or defend any litigation or proceeding before any governmental agency arising out of the operation of the Center as directed by the Board of Governors (the "Board") of the LLC.

Notwithstanding any provision to the contrary, the direction, coordination and management of all medical aspects of Center programs and operations, and the supervision of persons providing medical services, shall be under the direction and control of the medical director of the Center (the "Medical Director").

3. MANAGEMENT SERVICES

AmSurg shall have the responsibility to supervise, consult in and oversee the business operations of the Center and, subject to the terms of this Agreement and the general direction and control of the Board, shall have the responsibility for coordinating all business and administrative activities pertaining to the Center, including, but not in any way limited to, the following:

3.1. Assist the Center in operating in an efficient and business like manner;

3.2. Coordinate the purchase or lease of equipment, supplies and pharmaceuticals (including purchases through national purchasing programs) necessary for the operation of the Center;

3.3. Coordinate all reasonable and necessary actions to maintain all licenses, permits and certificates required for the operation of the Center, and to insure that all appropriate certification and accreditation available to the Center's operations are obtained;

3.4. Coordinate, together with the Medical Director, ongoing marketing programs to increase community and payor awareness of the Center;

3.5. Negotiate contracts for the provision of services by the Center with appropriate third party payors, both public and private;

3.6. Provide input and make recommendations to the LLC on the overall charge structure of the Center, and arrange for payment of such charges by others, when appropriate;

3.7. Oversee and direct the personnel performing accounting and bookkeeping services for the LLC in the operation of the Center, including, but not limited to, all actions necessary to (1) maintain the books of account, including all journals and ledgers, check register and payroll records, (2) post all patient and other charges, including necessary analyses and corrections, (3) establish adequate receivable, credit and collection policies and procedures, (4) process vendors' invoices and other accounts payable, (5) prepare payroll checks from time sheet summaries prepared under AmSurg's supervision, (6) prepare monthly bank reconciliations, and (7) establish patient direct pay and insurance billing procedures;

3.8. Develop and revise, subject to approval by the LLC, all necessary policies and operating procedures pertaining to each aspect of the Center's operations;

3.9. In conjunction with the Medical Director, hire, supervise, discipline and discharge all personnel working in the Center and providing direct patient care, as needed;

3.10. Arrange for the purchase of necessary insurance coverage for the Center;

3.11. Establish and administer accounting procedures and controls and systems for the development, preparation, and keeping of records and books of accounting relating to the business and financial affairs of the Center;

3.12. Oversee the preparation of unaudited annual financial statements for the operations of the Center and deliver a copy thereof to the LLC; furnish the LLC in a timely fashion with monthly operating reports and other reports reasonably requested by the LLC or any member of the LLC;

3.13. Prepare for Board review all capital and annual operating budgets of the LLC, as needed; and

3.14. Perform all duties herein required of it in good faith and with reasonable diligence and in a good and workmanlike manner so as to assure that the Center efficiently provides appropriate quality health care to patients.

4. COMPENSATION FOR SERVICES RENDERED BY AMSURG

For all services rendered by AmSurg under this Agreement, the LLC shall pay AmSurg a fee annually in an amount equal to 3% of Net Revenues (as defined below) of the LLC. Such fee shall be calculated and paid monthly in arrears. Payment will be made on or before the 10th day of each month.

"Net Revenues" means facility fee income less estimated (i) contractual allowances, (ii) allowances for bad debt, and (iii) charity care, all as reflected in the Center's monthly financial statements and as determined in accordance with generally accepted accounting principles.

In addition, the LLC shall reimburse AmSurg on a monthly basis for its out-of-pocket expenses incurred in connection with performing its obligations hereunder, including reasonable legal, accounting, tax return preparation, travel, lodging and meal expenses. AmSurg shall prepare an itemization of such out-of-pocket expenses on a monthly basis to be submitted to the LLC by the 15th date of the subsequent month.

5. TERM

The initial term of this Agreement shall be for six (6) years from the Effective Date (the "Initial Term"). The Agreement shall be renewable by the LLC at its option for ten (10) additional consecutive three (3) year terms after the Initial Term, on the same terms, conditions and provisions as contained herein, together with any authorized and approved amendments hereto.

6. DEFAULT AND TERMINATION

Either party shall be in default of this Agreement if it fails to perform any material term hereof or any amendments hereto, and such failure is not cured within thirty (30) days after receipt of written notification of such failure from the party not in default. In the event of such default, the non-defaulting party shall have the right to terminate this Agreement immediately by written notice to the other party. In the event AmSurg ceases to be a member of the LLC, either the LLC or AmSurg may terminate this Agreement upon 90 days prior written notice to the other.

7. ASSIGNMENT

AmSurg may assign its rights and duties under this Agreement to a related or successor entity; provided that no additional fees and expenses other than the fees and expenses described herein will be paid by the LLC as a result of such assignment without the prior approval of the Board. Upon any such assignment, all references to AmSurg in this Agreement shall be deemed to include such assignee.

8. ARBITRATION

All disputes arising under this Agreement shall be resolved by binding arbitration pursuant to the rules of the American Health Lawyers Association Dispute Resolution Service ("AHLA") then pertaining. The arbitration proceedings shall be held in Chattanooga, Tennessee or such other location as shall be mutually agreed by the parties. The procedures for conducting discovery in connection with any such arbitration proceeding shall be determined by the mutual agreement of the parties or, if the parties cannot agree, by the arbitrators. The arbitrators shall apply the substantive laws of the State of Tennessee and the United States.

The parties may, if they are able to do so, agree upon one arbitrator; otherwise, there shall be three arbitrators selected to resolve disputes pursuant to this Section 8, one named in writing by each party within fifteen (15) days after notice of arbitration is served upon either party by the other and a third arbitrator selected by the two arbitrators selected by the parties within fifteen (15) days thereafter.

If the two arbitrators cannot select a third arbitrator within such fifteen (15) days, either party may request that the AHLA select such third arbitrator. If one party does not choose an arbitrator within fifteen (15) days, the other party shall request that the AHLA name such other arbitrator. No one shall serve as arbitrator

who is in any way financially interested in this Agreement or in the affairs of either party.

Each of the parties hereto shall pay its own expenses of arbitration and one-half of the expenses of the arbitrators. If any position by either party hereunder, or any defense or objection thereto, is deemed by the arbitrators to have been unreasonable, the arbitrators shall assess, as part of their award against the unreasonable party or reduce the award to the unreasonable party, all or part of the arbitration expenses (including reasonable attorneys' fees) of the other party and of the arbitrators.

9. RIGHTS CUMULATIVE; NO WAIVER

Any rights or remedies of either party in the event of default are intended to be cumulative rather than exclusive. Moreover, if either party chooses not to insist upon strict performance of any provision of this Agreement, such choice shall not impair its rights to insist on strict performance in the event of subsequent acts of default and the waiver by a party of any breach of any provision of this Agreement by the other party shall not operate or be construed as a waiver of any subsequent breach by that party.

10. ACCESS TO BOOKS AND RECORDS OF CENTER BY GOVERNMENTAL OFFICIALS

Upon written request of the Secretary of Health and Human Services or the Comptroller General or any other duly authorized representatives thereof, AmSurg or any other related organization providing services with a value or cost of Ten Thousand Dollars ($10,000) or more over a twelve (12) month period, shall make available the Secretary those contracts, books, documents and records necessary to verify the nature and extent of the cost of providing its services. Such inspection shall be available up to four (4) years after such services are rendered.

11. NOTICE

Any notice required or permitted to be given under this Agreement shall be in writing and shall be deemed to have been properly made and delivered when mailed first class, postage prepaid, certified or registered mail, or overnight courier service as follows:

if to AmSurg:

AmSurg Corp.
1A Burton Hills Boulevard
Nashville, TN 37215
Attn: Claire M. Gulmi
Fax: (615) 665-3600

with a copy to:

J. James Jenkins, Jr.
Bass, Berry & Sims PLC
150 Third Avenue South, Suite 2800
Nashville, TN 37201
Fax: (615)742-2736

if to the LLC:

The Chattanooga Endoscopy ASC, LLC
1A Burton Hills Boulevard
Nashville, TN 37215
Attn: Claire Gulmi
Fax: (615) 665-3600

or to such other address as either party may from time to time specify by written notice to the other party. Any such notice shall be deemed to be given as of the date so delivered, if delivered personally, as of the date on which the same was deposited in the United States mail, postage prepaid, addressed and sent as aforesaid, or on the date received if sent by electronic facsimile.

12. MISCELLANEOUS

12.1. **Authorization for Agreement.** The execution and performance of this Agreement has been duly and validly authorized, executed and delivered by the LLC and AmSurg, and this Agreement constitutes the valid and enforceable obligation of the parties in accordance with its terms.

12.2. **Complete Agreement; Severability.** This instrument contains the entire agreement between the parties with respect to the subject matter hereof. All prior negotiations and understandings are merged herein, including, but not limited to, the 2001 Management Agreement. This Agreement may not be modified unless agreed to in a writing signed by both parties hereto.

Should any part of this Agreement be declared invalid by a court or regulatory body of competent jurisdiction, such decision shall not affect the validity of the remaining parts, and they shall remain in full force and effect.

12.3. **Applicable Law.** This Agreement shall be construed and enforced according to the laws of the State of Tennessee, without regard to its conflicts of law rules.

12.4. **No Presumption Created.** The parties acknowledge that they have independently negotiated the provisions of this Agreement, that they have relied upon their own counsel as to matters of law and application and that neither party has relied on the other party with regard to such matters. The parties expressly agree that there shall be no presumption created as a

result of either party having prepared in whole or in part any provisions of this Agreement.

13. LIMITED RENEGOTIATION

This Agreement shall be construed to be in accordance with any and all federal and state laws, including laws relating to Medicare, Medicaid and other third party payors. In the event there is a change in such laws, whether by statute, regulation, agency or judicial decision that has any material effect on any term of this Agreement, then the applicable term(s) of the Agreement shall be subject to renegotiation and either party may request renegotiation of the affected term or terms of this Agreement, upon written notice to the other party, to remedy such condition.

The parties expressly recognize that upon request for renegotiation, each party has a duty and obligation to the other only to renegotiate the affected term(s) in good faith and, further, each party expressly agrees that its consent to proposals submitted by the other party during renegotiation efforts shall not be unreasonably withheld.

Should the parties be unable to renegotiate the term or terms so affected so as to bring it/them into compliance with the statute, regulation, or judicial opinion that rendered it/them unlawful or unenforceable within thirty (30) days of the date on which notice of a desired renegotiation is given, then either party shall be entitled, after the expiration of said thirty (30) day period, to terminate this Agreement upon thirty (30) additional days written notice to the other party.

14. BUSINESS ASSOCIATE

The parties shall enter into a Business Associate Agreement, to the extent required by applicable law, including without limitation, the Health Insurance Portability and Accountability Act of 1996 and the privacy and security rules promulgated thereunder and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, and the regulations promulgated thereunder, all as amended from time to time.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives as of the day and year first above written.

2179453.4

AMSURG CORP.

By: _____

Title: Vice President

Chattanooga Endoscopy ASC, LLC,
a Tennessee limited liability company

By: _____
Chief Manager

A.6--Site Control

LEASE AGREEMENT
[AmSurg Standard Form – Last Revised 8/31/2010]

THIS LEASE AGREEMENT ("Lease") is made and entered into as of the 28th day of May, 2015, by and between Tallan Holdings Co., a Tennessee Corporation ("Landlord") and Chattanooga GI ASC, LLC., a Tennessee Limited Liability Corporation ("Tenant")

WITNESSETH:

1. Premises, Term, Rent and Buildout.

(a) Landlord leases to Tenant, and Tenant leases from Landlord, the space outlined on Exhibit A attached hereto (the "Premises") in the structure known as Riverside Business Center and located at Suite 117, 1501 Riverside Drive in Chattanooga, TN, (the "Building"). The Premises contain approximately 13,500 usable square feet of the approximately 136,778 rentable square feet contained in the Building as a whole.

(b) The term of this Lease shall commence upon the delivery of the Premises to the Tenant, as set forth herein, but in no event later than March 1, 2016 (the "Lease Commencement Date") and shall end at the end of the Fifteenth Lease year (February 28th 2031) (the "Initial Term"). The annual rental ("Base Rent"), for the entire Initial Term shall be as follows:

	Annual Base Rent	Monthly Base Rent	Base Rent Per Sq.Ft.
Year # 1	$108,000.00	$9,000.00	$8.00
Year # 2	$111,240.00	$9,270.00	$8.24
Year # 3	$114,577.20	$9,548.10	$8.49
Year # 4	$118,014.52	$9,834.54	$8.74
Year # 5	$121,554.95	$10,129.58	$9.00
Year # 6	$125,201.60	$10,433.47	$9.27
Year # 7	$128,957.65	$10,746.47	$9.55
Year # 8	$132,826.38	$11,068.86	$9.84
Year # 9	$136,811.17	$11,400.93	$10.13
Year # 10	$140,915.50	$11,742.96	$10.44

Year # 11	$145,142.97	$12,095.25	$10.75
Year # 12	$149,497.26	$12,458.10	$11.07
Year # 13	$153,982.18	$12,831.85	$11.41
Year # 14	$158,601.64	$13,216.80	$11.75
Year # 15	$163,359.69	$13,613.31	$12.10

,which Base Rent Tenant covenants to pay as and when due. Payments of Base Rent hereunder shall commence six (6) months from the date of possession of the premises by Tenant, (the "Rent Commencement Date"); no rent shall be payable during the period between the Lease Commencement Date and the Rent Commencement Date. All monthly installments of Base Rent shall be paid in advance, on or before the 1st day of each month, without demand, to Landlord at the address set forth hereafter. Each period commencing on January 1st and ending on the next December 31st is referred to herein as a "Lease Year". Base Rent for any partial months in which Base Rent is payable hereunder shall be prorated accordingly.

(c) Tenant will perform, at Tenant's cost and expense, the construction necessary to prepare the Premises for Tenant's occupancy, all pursuant to the plans and specifications that are attached hereto as Exhibit B. Tenant shall be solely responsible for all cost and expenses related to any improvements, renovations or construction required for its occupancy of the premises. Landlord shall not provide Tenant with a Tenant Improvement allowance. Tenant shall have the right to use the existing canopy located on the front of the building toward the south end of the building as shown on the attached Exhibit A-1.

(d) The Parties understand and agree that the Tenant's ability to use the Premises for its intended purpose is contingent upon the Tenant receiving a Certificate of Need (CON) from the Tennessee Certificate of Need Board. The Tenant is in the process of applying and shall apply no later than June 20, 2015 for said CON. Should Tenant's application for CON be disapproved, or if a CON is not obtained by the Tenant for any reason on or before December 31, 2015, this Lease shall become null and void and shall be of no further effect on either of the Parties. Upon acceptance or rejection of Tenant's CON, Tenant shall within five (5) days notify Landlord or such acceptance or rejection.

2. Appurtenances. Landlord grants to Tenant and covenants that Tenant shall have during the term of this Lease, at no additional cost to Tenant, the exclusive use of the Sixteen (16) parking spaces that are shown on the attached Exhibit A-2, and the non-exclusive use of all other parking spaces that are not marked as reserved for the exclusive use of another Tenant, or their guest and invitees, and the non-exclusive use of any and all public restrooms, elevators and all other common areas.

Landlord agrees and grants to Tenant the right to locate any and all mechanical equipment, necessary to support the Use of the Premises, on the site adjacent to and as

reasonably close to the building as practicable. Parties agree and understand that this equipment will include a generator of a size approximating a normal parking space, and may include additional HVAC or electrical equipment common to the use of the premises.

3. Renewal Term(s).

(a) Provided Tenant is not then in default hereunder beyond applicable periods of grace and/or notice and cure, Tenant may at its option renew this Lease for two (2) successive five (5) year periods commencing on the first day after the Initial Term or the then-previous renewal term, as applicable, upon all terms, conditions, and obligations set forth herein, except as provided in this Section 3. Tenant shall provide Landlord with notice at least ninety (90) days before the expiration of the Initial Term or the then-previous renewal term, as applicable, if it desires to exercise any of said options.

(b) Subject to Tenant's rights under subparagraph 3(c) below, the annual Base Rent, as set forth in subparagraph 1(b) above (or as set forth in subparagraph 3(c) hereof if Tenant has theretofore exercised its rights thereunder), shall be adjusted as of the first day of each Lease Year in each renewal term hereof as follows:

(i) In no event shall the annual Base Rent for any Lease Year be less than the annual Base Rent that is payable during the then-previous Lease Year.

(c) Upon written notice to Landlord at least ninety (90) days before the expiration of the Initial Term or any renewal term, as applicable, Tenant shall have the option to adjust the Base Rent payable under this Lease for the next succeeding renewal term to an amount equal to 100% of the then-current fair market rental rate of the Premises, as determined in accordance with the provisions hereof. The fair market rental rate of the Premises shall be agreed upon by Landlord and Tenant at least sixty (60) days prior to the commencement of the applicable renewal term. If Landlord and Tenant are unable to agree on the fair market rental rate of the Premises by such time, then Landlord and Tenant shall each appoint an independent MAI appraiser within ten (10) days. The appraisers so selected shall mutually agree upon a third independent MAI appraiser within five (5) days thereafter. Each of the three appraisers shall, within thirty (30) days of the selection of the third appraiser, submit to Landlord and Tenant a written appraisal of the fair market rental rate of the Premises. The fair market rental rate of the Premises shall be equal to the numerical average of the three appraised determinations; provided, however, that if the difference between any two of the appraisals is not more than 10% of the lower of the two, and if the third appraiser differs by more than 25% of the lower of the other two appraisals, then the numerical average of such two appraisals shall be determinative. Each party shall be responsible for the cost of the appraiser selected by such party, plus one-half of the cost of the appraiser that has been mutually appointed by the two appraisers. In the event that any appraiser selected is unwilling or unable to appraise the property, the party or the appraisers, as applicable, shall select another appraiser that is willing and able to appraise. The fair market rental rate, as determined by agreement of the parties or through appraisal process, shall be effective for the initial

Lease Year of the applicable renewal term, but shall be adjusted upward in each subsequent Lease Year of such renewal term to reflect an increase of 3% annually in the Base Annual Rent.

(d) Upon any change in the annual Base Rent payable hereunder with respect to any Lease Year, the monthly installments of Base Rent payable by Tenant under subsection 1(b) hereof shall automatically be adjusted to equal one-twelfth (1/12th) of the adjusted annual Base Rent amount.

4. Additional Rent. Tenant agrees to pay as "Additional Rent" Ten percent (10%) of the amount by which sums paid or incurred by Landlord during the Lease term for real estate taxes and special assessments, insurance premiums, and all other direct costs and expenses for the operation of the Building and the property of which the Building is a part and the repair, replacement and maintenance necessary to keep the Building and the property of which the Building is a part in good order, condition and repair, including but not limited to utilities other than utilities that are separately metered to tenants (collectively, the "Operating Expenses"). Notwithstanding the foregoing, Operating Expenses shall not include (a) any capital expenditures except to the extent that capital expenditures result in a decrease in Operating Expenses, (b) expenses that are subject to reimbursement by insurance proceeds, other tenants or third parties, (c) the cost of any services provided by Landlord for the sole benefit of other tenants of the Building; (d) marketing costs, including but not limited to, leasing commissions, attorney's fees in connection with negotiating leases, advertising and promotional expenses; (e) ground lease rental and/or any interest or principal payments for any mortgages encumbering the Building; (f) costs incurred by Landlord as a result of Landlord's violation of any laws, regulations or ordinances or breach of any agreements; or (g) payments to subsidiaries or affiliates of Landlord for goods or services which as a result of a non-competitive selection process exceed the cost of such goods or services if obtained by parties unaffiliated with Landlord. Moreover, it is not intended that Tenant be required to pay any part of increased tax assessments resulting from additional improvements constructed for other tenants in the Building after the Building has been fully completed and assessed.

Notwithstanding the forgoing, Tenant shall be required to pay to Landlord, within thirty (30) days after receipt of invoice from Landlord, any part of increased tax assessments resulting from any additional improvements constructed by Tenant in the Building.

Landlord shall be entitled to reasonably estimate the total amount of Additional Rent to be paid by Tenant during each Lease Year and, upon notice to Tenant of such estimate, to collect such estimate in twelve (12) equal installments, each such installment to be due and payable with each monthly rental installment payable under this Lease.

Within a reasonable time (but in any event within one hundred and twenty (120) days after the end of each Lease Year, Landlord shall submit to Tenant a statement of the actual amount of Operating Expenses and the Additional Rent due from Tenant hereunder for such Lease Year, and within thirty (30) days after receipt of such statement, Tenant shall pay the difference between the actual amount owed and the estimates paid during such Lease Year, or in the event of overpayment, Landlord shall credit the amount of such overpayment toward the next

monthly installments of Base Rent or refund such overpayment to Tenant. Landlord shall keep reasonably detailed books and records of all Operating Expenses. Tenant may review and/or audit Landlord's records relating to Operating Expenses, at Tenant's expense, during normal business hours.

5. Tenant's Repairs. Tenant will keep the Premises, including without limitation, interior walls, floors, ceiling, and light fixtures (but excluding any items that Landlord is required to repair pursuant to the terms of this Lease), as clean and in as good repair as same are on the Commencement Date or may be put in during the continuance thereof, reasonable wear and tear and damage by fire, other casualty, or condemnation excepted. Furthermore Tenant, at its sole expense, shall maintain and keep in good repair, replacement and working condition, any HVAC, Electrical and Plumbing systems / equipment installed by Tenant for its exclusive use in the Premises.

6. Landlord's Repairs and Utilities. Subject to reimbursement as provided for in Section 4 hereof, Landlord shall maintain and keep in good repair and working order the roof, exterior walls, sprinkler system, of the Building, the adjoining yard and parking lot, and all underground water and sewerage pipes. In addition to the above Landlord, at its sole expense, shall maintain and keep in good repair and working condition any existing HVAC system(s), electrical wiring and plumbing systems, that were installed prior to the lease commencement date as set forth above in Section 1, for the first three (3) years of the initial lease term. After the first three (3) years of the initial lease term the Tenant shall be responsible, at its sole expense, for the repair, replacement and working condition of all such HVAC system(s), electrical wiring and plumbing systems regardless if such were installed by Landlord or Tenant.

Subject to reimbursement as provided for in Section 4 hereof, Landlord shall be responsible for the payment of all bills and/or assessments for electrical, natural gas, water and sewer and other utilities serving the Premises and the Building unless such utilities are separately metered and billed directly to Tenant.

Landlord reserves the right to interrupt or suspend any such services when necessary, either because of accident or emergency or because of the necessity for repairs, alterations, replacements of improvements. Landlord shall not be liable for any damages or injuries to Tenant or others nor shall there be an abatement of rent arising from the failure by Landlord to furnish such services or from the interruption or suspension of such services and no such failure to furnish such services shall be deemed an actual or constructive eviction of Tenant. Landlord shall, to the extent possible, give Tenant reasonable notice of any interruption or suspension of such services and Landlord shall use reasonable diligence to restore such services as soon as possible in the event of such failure, interruption or suspension.

7. Right of Entry. Landlord may at reasonable times and on reasonable notice to Tenant enter the Premises to inspect them and make any repairs required by Section 6 or required by Section 5 that Tenant has failed to make (provided that Landlord shall only be entitled to make such repairs described in Section 5 if Tenant has failed to make such repairs within fifteen (15) days after written notice thereof from Landlord), and during the ninety (90) days preceding the expiration of this Lease, may show the Premises to persons who may wish to lease same,

provided Tenant's occupancy is not interfered with. If Landlord makes any repairs required to be made by Tenant under Section 5, Tenant shall pay Landlord as additional rent a sum equal to the amounts expended by Landlord plus interest thereon at the rate of ten percent (10%) per annum within ten (10) days after Landlord presents Tenant with a statement setting forth the repairs made and the amounts expended.

8. Renovations and Alterations of Premises. Subject to Landlord's approval of all plans and specifications for material renovations and alterations, which approval will not be unreasonably withheld, conditioned, or delayed, and subject to the condition that Tenant shall allow no lien to be placed against the Premises or the Building, Tenant shall have the right, at its sole cost and expense, to renovate, alter, and use the Premises in connection with its business and to make related improvements. All alterations, additions, repairs, replacements and improvements made to or upon the Premises shall be deemed to be part of the Premises and shall become the property of Landlord upon the expiration or termination of this Lease; provided, however, that all medical fixtures, machinery and equipment that are installed by Tenant and removable without materially damaging the Premises (unless such damage is repaired by Tenant) shall remain the property of Tenant.

9. Fire or Other Casualty. If the Premises should be damaged or destroyed by fire or other casualty (a) so as to cause a material alteration in the character of the Premises and to prevent Tenant from using them in substantially the manner theretofore used, and (b) such that the same cannot reasonably be repaired by Landlord within one hundred twenty (120) days after the occurrence of such casualty, then either Landlord or Tenant may terminate this Lease upon giving notice to the other within thirty (30) days after the casualty occurs. Should such termination occur on any day other than the last day of a monthly rental period, any unearned prepaid rental shall be refunded to Tenant.

If the Premises are materially damaged by fire or other casualty and neither party elects to terminate this Lease, or if the Premises should be damaged by fire or other casualty and still be fit for Tenant's continued use in substantially the same manner as theretofore used or if the same can reasonably be repaired within the aforesaid 120-day period, then this Lease shall continue in effect and the Premises shall be restored by Landlord to its condition immediately prior to the casualty. While such restoration is in progress and continuing until the 60th day after such restoration is complete, Tenant shall be entitled to a fair and appropriate abatement of the rental to be paid, said abatement to be based on the amount and value of the Premises that remains useable by Tenant during the restoration period. Should the damage necessitating such restoration occur on any day other than the last day of a monthly rental period, then the amount of prepaid rental to be refunded to Tenant shall be based on the amount and value of undamaged space used by Tenant during the remainder of said monthly rental period.

10. Surrender of Premises. At the expiration of the term of this Lease, Tenant shall peaceably yield up to Landlord the Premises and all erections and additions made thereto except as hereinbefore provided, in good repair in all respects, reasonable use, wear and tear and damage by fire or other casualty or by condemnation excepted provided, however, that Tenant shall remove and keep all medical fixtures, machinery and equipment installed by Tenant and removable without materially damaging the Premises (unless such damage is repaired by Tenant).

11. Holding Over. Should Tenant hold over the term hereby created with the consent of Landlord, Tenant shall become a tenant from month-to-month at a monthly rental not to exceed 150% of the then current lease rate payable hereunder and otherwise upon the covenants and conditions in this Lease contained, and shall continue to be such tenant until thirty (30) days after either party serves upon the other notice of intention to terminate such monthly tenancy. As long as Tenant is negotiating to renew the lease in good faith a hold over penalty shall not be charged to Tenant. Should such termination occur on any day other than the last day of any rental period, any unearned prepaid rent shall be refunded to Tenant immediately following surrender of the Premises to the Landlord. Upon written notice to Landlord not less than 90 days prior to the termination of any term of this Lease (initial or renewal term) indicating Tenant's intention to Hold Over, the term of this lease shall be extended for a period not to exceed 180 days beyond the termination date. Tenant's notification shall declare the period of time for which it will hold over, and a non-refundable payment equal to the base rent for the extended period shall be immediately payable to the Landlord.

12. Use of Premises. The Premises shall be used for the operation of an ambulatory surgery center and related medical purposes. Tenant will not at any time use or occupy the Premises in violation of laws, ordinances, or regulations of any government or agency having jurisdiction or in violation of Landlord's insurance contract(s).

13. Indemnity; Insurance. Tenant shall procure and maintain the following policies of insurance:

(a) Property insurance covering (i) all personal property and (ii) all trade fixtures and tenant improvements. Subject to reimbursement as provided for in Section 4 hereof, Landlord shall procure and maintain property insurance on the Building. All such property insurance shall be against damage by fire and casualty in the form of ISO Causes of Loss – Special Form for the full replacement value of the property insured.

(b) Commercial general liability insurance naming Landlord as an additional insured in at least the amount of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate.

To the extent not covered by insurance, Tenant will save, indemnify and hold Landlord harmless from any and all liability or any injury, loss or damage to person or property arising out of the of the negligence or willful misconduct of Tenant. To the extent not covered by insurance, Landlord will save, indemnify and hold Tenant harmless from any and all liability or any injury, loss or damage to person or property arising out of the negligence or willful misconduct of Landlord.

14. Quiet Enjoyment. As long as Tenant is not in default hereunder, Landlord covenants that Tenant shall peaceably hold and enjoy the Premises, subject to the terms of this Lease, for the Lease Term and any extensions or renewals thereof

15. Eminent Domain. If the whole of the Premises shall be taken or condemned by any competent authority for any public use or purpose or if such portion thereof shall be taken or condemned as shall materially change the character of the Premises so as to prevent Tenant from

using them in substantially the same manner as theretofore used, the term hereby granted shall cease on the day prior to the taking of possession by such authority or the day prior to vesting of title in such authority, whichever first occurs, and an appropriate pro rata portion of any rent paid in advance by Tenant shall be refunded.

If a portion of the Premises shall be condemned or taken, and if such taking does not result in a material alteration in the character of the Premises so as to prevent Tenant from using them in substantially the same manner as theretofore used, then this Lease shall continue in effect, and the Premises shall be restored to a complete architectural unit by Landlord and any damage to the Premises shall be repaired by Landlord. After the date Tenant is required to surrender possession of the portion taken, the rental payable hereunder shall be reduced in proportion to the decrease in the fair rental value of the Premises.

If all or a portion of the adjoining parking area shall be condemned or taken so as to deprive Tenant of necessary parking or so as to in some other way materially affect the Tenant's ability to conduct its business or if Tenant's means of ingress and egress to and from the Premises are materially affected by any taking or condemnation, then Tenant may at its option cancel and terminate this Lease upon giving Landlord notice within thirty (30) days of such taking. In the event Tenant shall elect not to cancel and remain in possession and occupation of the Premises, however, the terms and conditions of this Lease shall remain in full force and effect.

The entire award of damages or compensation for a taking of the Premises, whether such taking be in whole or in part, shall belong to and be the property of Landlord, except for such compensation as may be made for Tenant's moving or relocation expenses, Tenant's business interruption losses and for the taking of Tenant's trade fixtures, which compensation shall belong to and be the property of Tenant.

If the Premises shall be taken or condemned by any governmental authority for temporary use or occupancy, this Lease shall continue in full force and effect without reduction or abatement of rent, and the rights of the parties shall be unaffected by the other provisions of this Section. In the event of such temporary taking the entire award of damages in respect of the Premises shall belong to Tenant and Landlord assigns Tenant any and all interest it may have in such award. To the extent Tenant is prevented by such temporary taking or occupancy from fulfilling its obligations hereunder, Tenant's failure to do so shall not be deemed a default under this Lease.

16. Assignment and Subleasing. The Tenant may not assign or encumber this Lease or sublet the Premises, either in whole or in part, without the prior written consent of Landlord, which consent will not be unreasonably withheld, conditioned, or delayed. Consent to one assignment or subletting will not be deemed a consent to any other. In the event of any assignment or subletting, Tenant shall remain fully responsible under this Lease. Notwithstanding the foregoing, Tenant may sublet the Premises or assign this Lease, in whole or in part, to any affiliate of Tenant, including but not limited to any subsidiary or parent, without the prior written consent of Landlord.

17. Attorney's Fees. In the event it becomes necessary for either party to employ an attorney to enforce compliance with any of the covenants or agreements herein contained, the losing party shall be liable to the prevailing party for reasonable attorney's fees, costs and expenses.

18. Notice. Any notices required to be sent hereunder shall be hand delivered or sent by a nationally recognized overnight delivery service (such as FedEx) or by certified mail (return receipt requested) to the following addresses:

LANDLORD:	Tallan Holdings Co. P.O. Box 11549 Chattanooga, TN 37402 Atten: Beth Robertson
TENANT:	Chattanooga GI ASC, LLC. % AmSurg Corp. 1A Burton Hills Boulevard Nashville, TN 37215 Attn.: Claire Gulmi
with a copy to	Bass, Berry & Sims PLC 150 3rd Avenue South, Suite 2800 Nashville, TN 37201 Attn: J. James Jenkins, Jr.

19. Default and Remedies and Late Charges. Each of the following events shall constitute a default or breach of this Lease by Tenant:

(a) If Tenant, or any successor or assignee of Tenant while in possession, shall file a petition in bankruptcy or insolvency or for reorganization under any bankruptcy act, or shall voluntarily take advantage of any such act or shall make assignment for the benefit of creditors.

(b) If involuntary proceedings under any bankruptcy laws or insolvency act shall be instituted against Tenant, or if a receiver or trustee shall be appointed for all or substantially all of the property of Tenant, and such proceedings shall not be dismissed or the receivership or trusteeship vacated within ninety (90) days after the institution or appointment.

(c) If Tenant shall fail to pay Landlord any rent or additional rent together with any interest thereon within ten (10) days after Landlord notifies Tenant that it is unpaid.

(d) If Tenant shall fail to perform or comply with any of the other conditions of this Lease within thirty (30) days after notice by Landlord to Tenant specifying the condition to be performed or complied with; or, if the performance cannot be reasonably

had within the thirty (30) day period, Tenant shall not in good faith have commenced performance within the thirty (30) day period and shall not diligently proceed to completion of performance.

In the event of any default hereunder, Landlord at any time thereafter, may re-enter the Premises and expel, remove, and put out Tenant or any person or persons occupying the Premises and may remove all personal property therefrom. Upon re-entry Landlord may, at its option, relet the Premises or any part thereof as the agent of Tenant, and Tenant shall pay Landlord the difference between the rent hereby reserved for the portion of the term remaining at the time of re-entry and the amount received under such reletting for such portion of the term. Upon re-entry Landlord may at its option, terminate this Lease and at any time thereafter recover from Tenant all sums then due as well as the present value of the amount by which all rent and other payments to be made by Tenant for the remainder of the Lease term exceed the reasonable rental value of the Premises for the remainder of the Lease term.

All actions taken by Landlord pursuant to this Section shall be without prejudice to any other remedies that otherwise might be used for the collection of arrears of rent or for the preceding breach of covenant or conditions.

If Tenant has failed to cure any default hereunder within the applicable periods of grace and/or notice and cure set forth above, Landlord may elect, but shall not be obligated, to comply with any condition, agreement, or term required hereby to be performed by Tenant, and Landlord shall have the right to enter the Premises for the purpose of correcting or remedying any such default and to remain until the default has been corrected or remedied, but any expenditure for such correction by Landlord shall not be deemed to waive or release the default of Tenant or the right of Landlord to take any action as may be otherwise permissible hereunder in the case of any default.

In the event Tenant fails to pay any installment of Base Rent when due, or any payment of Additional Rent, said delinquent installment or payment shall bear interest at the rate of the lesser of twelve percent (12%) per annum or the maximum non-usurious interest rate permissible by law from the date such payment was due until paid. Tenant covenants to pay any such sums, and Landlord shall have (in addition to any other right or remedy of Landlord) the same rights and remedies in the event of non-payment thereof by Tenant as set forth above. Tenant hereby acknowledges that in addition to lost interest, the late payment by Tenant to Landlord of Base Rent, or any Additional Rent, or other sums due hereunder, will cause Landlord to incur other cost not contemplated in this Lease, the exact amount of which is extremely difficult and impractical to ascertain. Such other costs include, but are not limited to, processing and administrative and accounting costs. Accordingly, if any installment of Base Rent or any other sum due from Tenant shall not be received by Landlord within ten (10) days after such amount shall be due, Tenant shall also pay to Landlord an additional sum equal to the greater of One Hundred Dollars ($100.00) or five percent (5%) of the amount overdue as a late charge for every month or portion thereof that amount remains unpaid. The parties hereby agree that (a) such late charge represents a fair and reasonable estimate of the costs Landlord will incur in processing each delinquent payment by Tenant, (b) that such late charge shall be paid to Landlord as liquidated damages for each delinquent payment, and (c) that the payment of late charges and the payment of interest are distinct and separate from one another in that the payment of interest is to

compensate Landlord for the use of Landlord's money by Tenant, while the payment of late charges is to compensate Landlord for the additional administrative expenses incurred by Landlord in handling and processing delinquent payments.

20. No Waiver. The subsequent acceptance of rent hereunder by Landlord shall not be deemed a waiver of any preceding breach of any obligation hereunder by Tenant other than the failure to pay the particular rental so accepted, and the waiver of any breach of any covenant or condition by Landlord shall not constitute a waiver of any other breach regardless of knowledge thereof.

21. Patient Privacy. Notwithstanding any of Landlord's rights to enter the Premises pursuant to the terms of this Lease, Landlord shall not cause Tenant to in any way violate any laws, regulations or ordinances intended to protect the rights and privacy of Tenant's patients, including those relating to any and all patient records, which at any time, Tenant shall be able to secure in locked storage units or remove from the Premises.

22. Gender. Wherever appropriate herein, the words "Landlord" and "Tenant" and the pronouns referring thereto, shall be construed singular or plural, masculine, feminine or neuter as the facts warrant.

23. Broker. With the exception of Acumen Realty, who exclusively represents the Tenant in the transaction and will be paid by the Landlord as per the terms set forth in a separate agreement, each party warrants and represents that no broker was involved in negotiating or consummating this Lease, and agrees to indemnify and hold harmless the other from and against any and all claims for brokerage commissions arising out of any communications or negotiations had by it with regard to the Premises.

24. Waiver of Subrogation. Landlord and Tenant hereby waive all rights of recovery and causes of action that either has or may have or that may arise hereafter against the other for any damage to premises, property or business caused by any perils covered or coverable by the property insurance required under Section 9 of this Lease, or for which either party may be reimbursed as a result of insurance coverage affecting any loss suffered by it; provided, however, that the foregoing waivers shall be ineffective if they invalidate any policy of insurance of the parties hereto, now or hereafter issued. Landlord and Tenant will use their best efforts to have their respective insurance companies waive their rights of subrogation as contemplated herein.

25. Signs. Tenant shall not place on any portion of the Premises any sign or advertising matters without first obtaining Landlord's written approval and consent, which consent shall not be unreasonably withheld or delayed. Tenant agrees to maintain such signs or advertising matter as are approved by Landlord in good condition and repair. All signs shall comply with applicable ordinances or other governmental restrictions, and the determination of such requirements and prompt compliance therewith shall be the responsibility of the Tenant.

26. Subordination. Upon written notice by Landlord to Tenant, this Lease shall be and become subject and subordinate to any and all first mortgages or deeds of trust now existing, or that hereafter may be executed, covering the Building or the Premises, for the full amount of

all advances made or to be made thereunder and without regard to the time or character of such advances, together with interest thereon, and subject to all the terms and provisions thereof. Tenant agrees to execute, acknowledge and deliver upon request any and all documents or instruments requested by Landlord or necessary or proper to insure the subordination of this Lease to any such mortgages or deeds of trust; provided, however, that the foregoing provisions with respect to such subordination shall not be effective unless the owner or holder of any such mortgage or deed of trust shall execute with Tenant a non-disturbance and attornment agreement under which said owner or holder shall agree (on its own behalf and on behalf of any purchaser at foreclosure) not to disturb Tenant's possession of the Premises under this Lease, except in accordance with the terms hereof. Tenant hereby agrees to attorn to any person, firm or corporation purchasing or otherwise acquiring the Building or the Premises at any sale or other proceeding or pursuant to the exercise of any other rights, power or remedies under such mortgages or deeds of trust, as if such person, firm, or corporation had been named as Landlord herein. Landlord hereby represents that the only mortgage currently encumbering the Building or the Premises is in favor of _____. [We will need SNDA from the existing lender.]

Notwithstanding anything to the contrary above, The term "Landlord" as used in this Lease means only the present owner of the Building, so that in the event of any sale or sales thereof, the Landlord who is a grantor in any such sale shall be and hereby is entirely freed and relieved of all of the obligations of Landlord hereunder. Any such sale or sales of the Building, or any interest therein, shall be subject to this Lease and it shall be deemed and construed without further agreement that the purchaser at any such sale has assumed and agreed to carry out any and all obligations of Landlord under this Lease so long as such purchaser shall be the owner of the Building.

27. Estoppel Letters. Either party hereto shall at any time and from time to time upon not less than ten (10) days prior written notice from the other execute, acknowledge and deliver to the requesting party a statement in writing certifying that this Lease is unmodified and in full force and effect (or if modified, stating the nature of such modification and certifying that this Lease, as so modified, is in full force and effect), and the dates to which the rental and other charges are paid in advance, if any, and acknowledging that there are not, to the certifying party's knowledge, any uncured defaults on the part of the other party hereunder, and that no event has occurred that, by the giving of notice or the passage of time or both, would constitute a default, or specifying such defaults or events if they are claimed. Any such statement requested by either party may be relied upon by any prospective purchaser or encumbrancer of the Building or the Premises. Failure of a party to deliver such statement within such time shall be conclusive upon such party that this Lease is in full force and effect, without modification, except as may be represented by the requesting party, that there are no uncured defaults in the requesting party's performance, and that not more than two months rental has been paid in advance.

28. Heirs, Successors, and Assigns. All the terms, covenants, and conditions hereof shall be binding upon and inure to the benefit of the heirs, executors, administrators, successors, and assigns of the parties hereto.

29. Waiver of Security Interests. Landlord hereby waives any and all security interests, liens, and other rights and interests, whether granted by statute or otherwise, in and to any and all fixtures, furniture, equipment and other personal property of Tenant.

30. Memorandum Lease. A Memorandum of Lease in substantially the form attached hereto as Exhibit C shall be executed by the parties hereto and recorded in the applicable land records within a reasonable time after the final execution of the Lease.

31. Entire Agreement. The entire understanding between the parties is set out in this Lease, this Lease supersedes and voids all prior proposals, letters and agreements, oral or written, and no modification or alteration of this Lease shall be effective unless evidenced by an instrument in writing signed by both parties. The law of the State of Tennessee shall be applicable.

32. Rules and Regulations:

(a) Tenant, Tenant's agents, employees, invitees and visitors shall observe and comply with the rules and regulations attached hereto and made a part hereof as Exhibit "D", and such further reasonable rules and regulations as Landlord may prescribe on written notice to Tenant, for the safety, care and cleanliness of the Building, and the comfort, quietness and convenience of other occupants of the Building. Such rules and regulations may be changed or amended by Landlord in its sole judgment at any time and from time to time. Such rules and regulations shall not amend or modify the terms and conditions of this Lease, and any conflict between such rules and regulations and the provisions of this Lease shall be controlled by the provisions of this Lease.

(b) Landlord shall incur no liability, and Tenant shall not be relieved of any obligation under this Lease because of any interference or disturbance of Tenant's use and occupancy of the Premises, or breach of or non-compliance with any rule or regulation, or amendment or addition thereto, by third persons, including other tenants of the Building. Landlord, however, will make reasonable efforts to protect Tenant from said interference, disturbance, breach, or non-compliance.

33. Rent Tax: In the event that any Federal, State or local law is passed during the Lease Term, or any extension or renewal thereof, requiring the payment of a tax or assessment based on the amount of rent to be paid by Tenant under this Lease, or in any other manner subjecting the rent provided in this Lease to any other form of tax by whatever name it may be designated, such tax shall be the obligation of and shall be in addition to the rent to be paid by Tenant as specified in this Lease.

34. Security Deposit: In lieu of a Security Deposit, Tenant hereby agrees to provide Landlord with financial statements for Landlord's review, reflecting Tenant's financial strength and credit worthiness. In addition to the financial statements Tenant shall pay the first months rental payment to Landlord upon the full execution of this lease by both parities.

35. Transfer of Tenant: Intentionally Deleted.

36. Confidentiality Clause: Tenant hereby expressly agrees that without the prior written consent of landlord it will keep all terms and conditions of this lease agreement including without limitation the rental rates, strictly confidential and neither tenant nor any representative thereof will communicate with any member of its organization or any other third party the terms and conditions of this lease. Tenant hereby acknowledges that a breach of this condition would irrepreably harm landlord and that tenant agrees that in addition to any other remedy to which landlord may be entitled at law or in equity including consequential damages, landlord shall be entitled to such mandatory injunctive or other relief as appropriate to carry out the intent of the parties under this agreement.

[The remainder of this page has been intentionally left blank.]

IN WITNESS WHEREOF, the parties hereto have set their respective hands or caused this instrument to be duly executed on or as of the day and date first above written.

LANDLORD:

Tallan Holdings Co.

By: Beth Robertson
Name: Beth Robertson
Title: Secretary

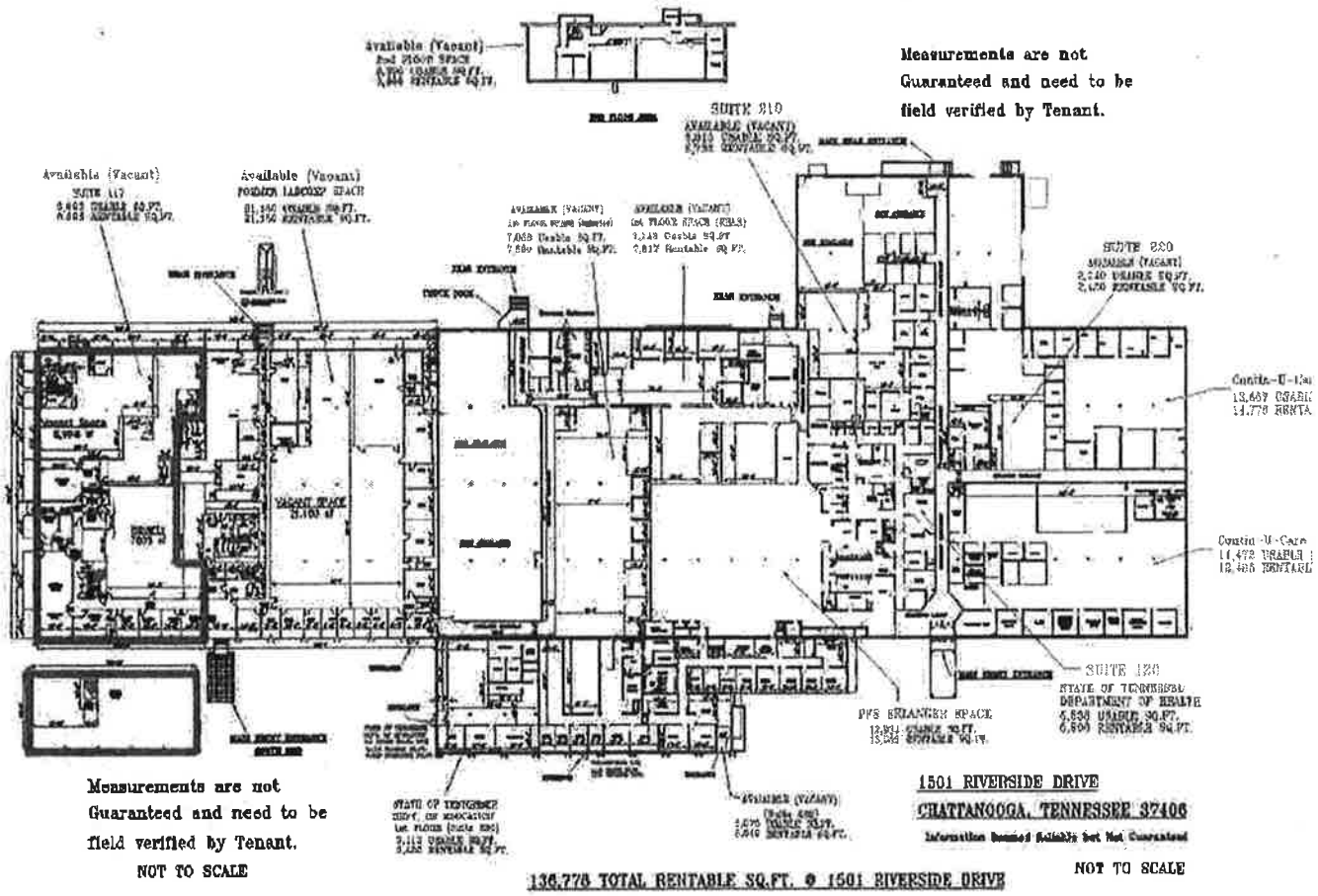
TENANT:

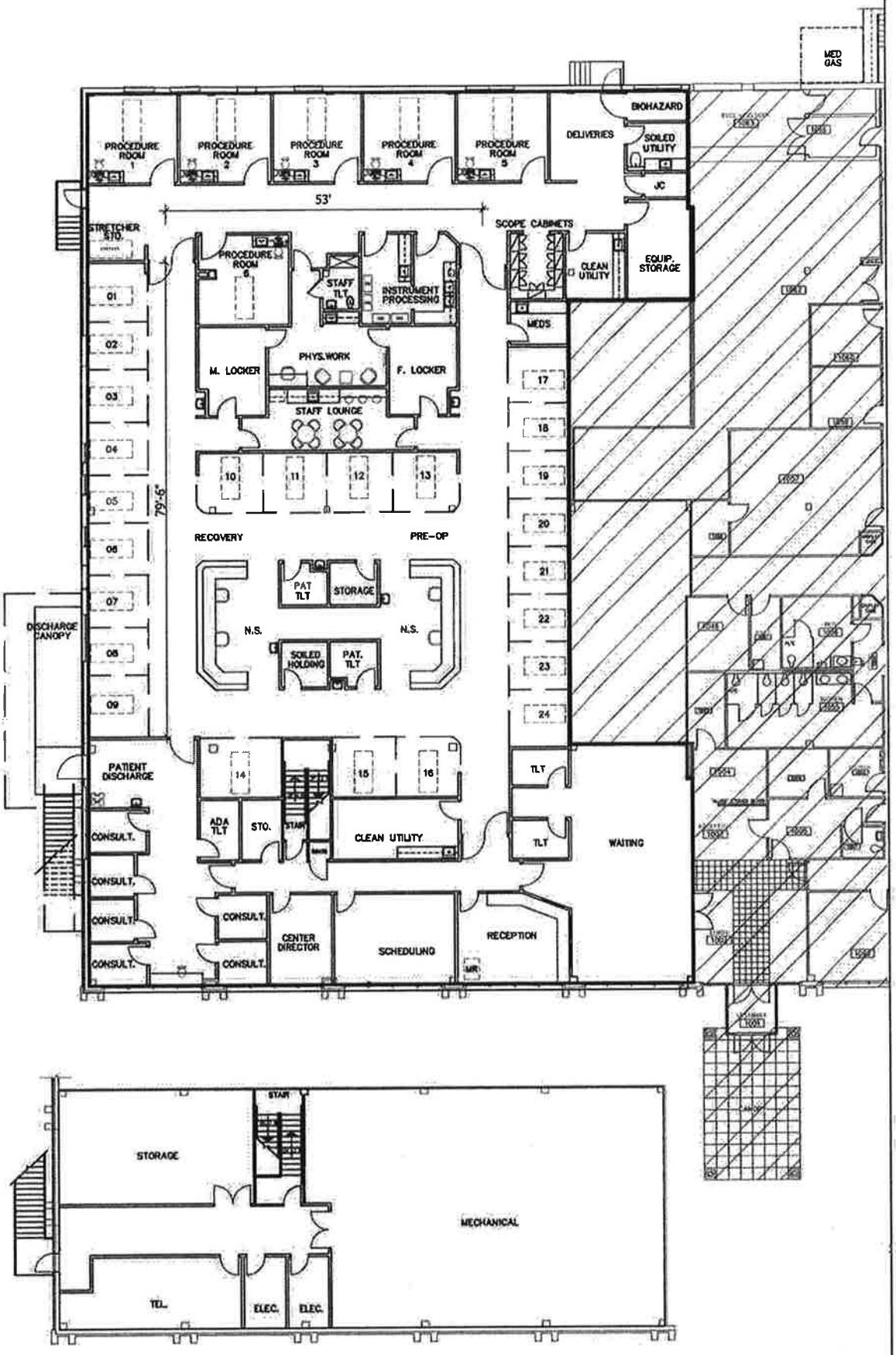
Chattanooga GI ASC, LLC.

By:
Name: Claire Gutowski
Title: Secretary

EXHIBIT A

[Location of Premises]





Digestive Disorders Endoscopy Center Relocation

HMK ARCHITECTS PLLC

MAY 27, 2015 - PROPOSED PLAN

NOT FOR CONSTRUCTION

13,500 SF

Exhibit "A"

0 4' 8' 16' 32'

EXHIBIT A-1

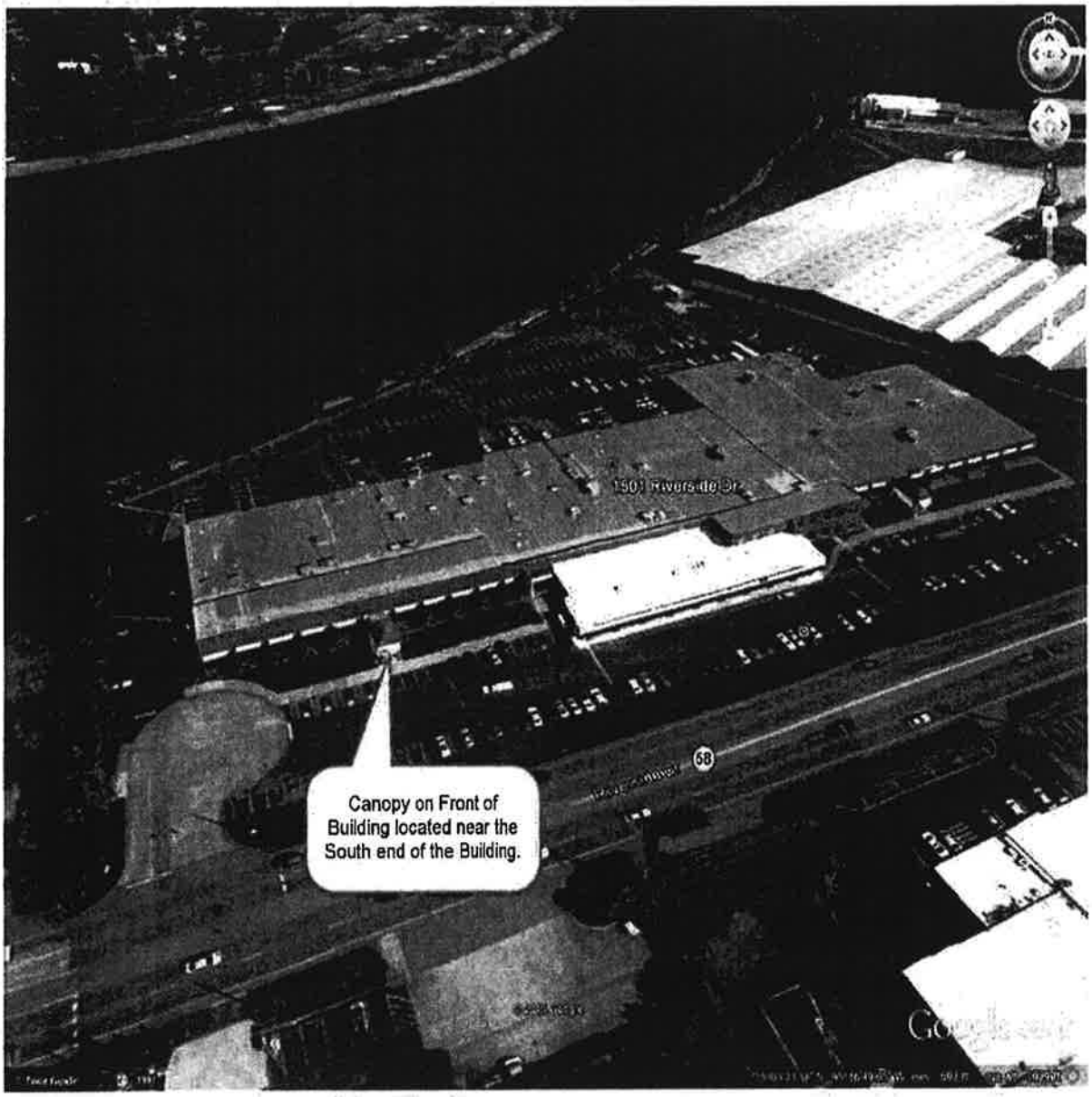

Canopy on Front of Building located near the South end of the Building.

EXHIBIT A-2

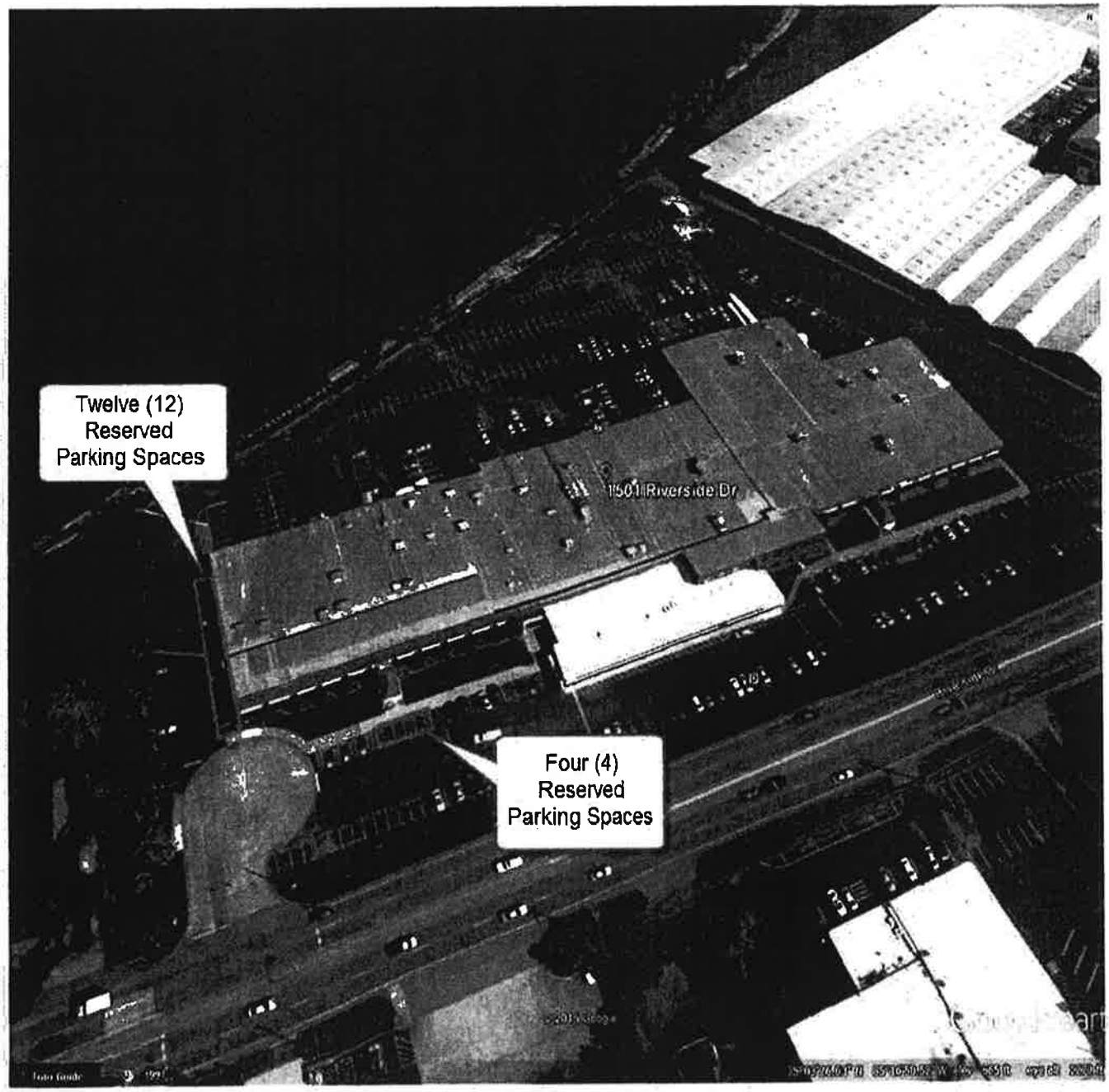

Twelve (12)
Reserved
Parking Spaces
1501 Riverside Dr
Four (4)
Reserved
Parking Spaces

EXHIBIT B

[Plans and Specifications]

EXHIBIT "D"
RULES AND REGULATIONS

1. The rights of each Tenant in entrance, corridors, escalators and elevators (as applicable) servicing the Building are limited to ingress to and egress from such Tenant's Premises for the Tenant and its employees, licensees and invitees, and no Tenant shall use, or permit the use of, the entrances, corridors, escalators or elevators (as applicable) for any other purpose. No Tenant shall invite to the Tenant's Premises, or permit the visit of, persons in such numbers or under such conditions as to interfere with the use and enjoyment of any of the sidewalks, plazas, entrances, corridors, escalators, elevators (as applicable) and other facilities of the Building by any other Tenants. No Tenant shall obstruct, or permit the obstruction of, any of the sidewalks, plazas, entrances, corridors, escalators, elevators, fire exits or stairways (as applicable) of the Building. Landlord reserves the right to control and operate the public portions of the Building and the public facilities, as well as facilities furnished for the common use of the Tenants, in such manner as in its reasonable judgment deems best for the benefit of the Tenants generally.

2. Landlord may refuse admission to the Building outside of normal Building business hours on business days to any person not known to the watchman in charge, or not having a pass issued by Landlord or by the Tenant whose Premises are to be entered, or not otherwise properly identified, and Landlord may require all persons admitted to or leaving the Building outside of normal Building business hours on business days to provide appropriate identification. Each Tenant shall be responsible for all persons for whom it issues any such pass and shall be liable to Landlord for all acts or omissions of such persons. Any person whose presence in the Building at any time shall, in the judgment of Landlord, be prejudicial to the safety, character or reputation of the Building or of its Tenants may be denied access to the Building or may be ejected therefrom. During any public excitement or commotion, Landlord may prevent all access to the Building by closing the doors or otherwise for the safety of the Tenants and protection of property in the Building.

3. The cost of repairing any damage to the public portions of the Building or to the public facilities or to any facilities used in common with other Tenants, caused by a Tenant or its employees, agents, contractors, licensees or invitees, shall be paid by such Tenant.

4. No awnings or other projects shall be attached to the outside walls of the Building. No curtains, blinds, shades or screens which are different from the standards adopted by Landlord for the Building shall be attached to, or hung in, or used in connection with, any exterior window or door of the Premises of any Tenant, without the prior written consent of Landlord. Such curtains, blinds, shade or screens must be of a quality, type, design and color approved by Landlord, and attached in the manner approved by Landlord.

5. No lettering, sign advertisement, notice or object shall be displayed in or on the exterior windows or doors of, or on the outside of, any Tenant's Premises, or at any point inside any Tenant's premises where the same might be visible outside of such Premises, without the prior written consent of Landlord. In the event of the violation of the foregoing by any Tenant, Landlord may remove such object or objects without any liability and may charge the expense incurred in such removal to the Tenant violating this rule. Interior signs, elevator designations and lettering on doors and the Building directory shall (as applicable), if and when approved by Landlord, be inscribed, painted or affixed for each Tenant by Landlord at the expense of such Tenant, and shall be of a size, color and style acceptable to Landlord.

6. The sashes, sash doors, skylights, windows and doors that reflect or admit light and air into the halls, passageways or other public places in the Building shall not be covered or obstructed by any Tenant, nor shall any bottles, parcels or other articles be placed on the window sills or on the peripheral air conditioning enclosures, if any.

7. No showcases or other articles shall be put in front of, or affixed to any part of, the exterior of the Building, nor placed in the halls, corridors or vestibules of the Building.

8. No bicycles, vehicles, animals, fish or birds of any kind shall be brought into or kept in or about the premises of any Tenant or the Building.

9. No noise, including but not limited to, music or the playing of musical instruments, recordings, radio or television, which, in the reasonable judgment of Landlord, might disturb other Tenants in the Building, shall be made or permitted by any Tenant. Nothing shall be done or permitted in the Premises of any Tenant that would impair or interfere with the use or enjoyment by any other Tenant of any other space in the Building.

10. No Tenant, nor any Tenant's contractors, employees, agents, visitors or licensees, shall at any time bring into or keep upon the premises or the Building any inflammable, combustible, explosive or otherwise dangerous fluid, chemical or substance.

11. No additional locks or bolts of any kind shall be placed upon any of the doors or windows in any Tenant's Premises and no lock on any door therein shall be changed or altered in any respect. Tenant shall receive two (2) keys to the Premises from Landlord at no charge. Additional keys for a Tenant's Premises and toilet rooms shall be procured only from Landlord who may make a reasonable charge therefor. Each Tenant shall, upon the termination of its Tenancy, turn over to Landlord all keys and Building access cards if applicable for such Tenant's premises and toilet rooms, either furnished to, or otherwise procured by, such Tenant, and in the event of the loss of any keys furnished by Landlord, such Tenant shall pay to the Landlord the cost thereof.

12. All removals, or the carrying in or out of any safes, freight, furniture, packages, boxes, crates or any other object or matter of any description must take place during such hours and in such elevators and in such manner as Landlord or its agent may determine from time to time. The persons employed to move safes and other heavy objects shall be reasonably acceptable to Landlord. Arrangements will be made by Landlord with any Tenant for moving large quantities of furniture and equipment into or out of the Building. All labor and engineering costs incurred by Landlord in connection with any moving specified in this rule, including a reasonable charge for overhead and profit, shall be paid by such Tenant to Landlord, on demand.

13. Landlord reserves the right to inspect all objects and matter to be brought into the Building and to exclude from the Building all objects and matter which violate any of these Rules and Regulations or the Lease of which this Exhibit is a part. Landlord may require any person leaving the Building with any package or other object or matter to submit a pass, listing such package or object or matter, from the Tenant from whose Premises the package or object or matter is being removed, but the establishment and enlargement of such requirement shall not impose any responsibility on Landlord for the protection of any Tenant against the removal of property from the Premises of such Tenant. Landlord shall in no way be liable to any Tenant for damages or loss arising from the admission,

exclusion or ejection of any person to or from the Premises or the Building under the provisions of this Rule or Rule 2 hereof.

14. Landlord shall have the right to prescribe the weight and position of safes and other objects of excessive weight, and no safe or other object whose weight exceeds the lawful load for the area upon which it would stand shall be brought into or kept in any Tenant's Premises. If, in the judgment of Landlord, it is necessary to distribute the concentrated weight of any heavy object, the work involved in such distribution shall be done at the expense of Tenant and in such manner as Landlord shall determine.

15. No machinery or mechanical equipment other than ordinary portable business machines may be installed or operated in any Tenant's Premises without Landlord's prior written consent, which consent shall not be unreasonably withheld or delayed, and in no case (even where the same are of a type so excepted or consented to by Landlord) shall any machines or mechanical equipment be so placed or operated as to disturb other Tenants; but machines and mechanical equipment which may be permitted to be installed and used in a Tenant's premises shall be so equipped, installed and maintained by such Tenant as to prevent any disturbing noise, vibration or electrical or other interference from being transmitted from such premises to any other area of the Building.

16. Landlord, its contractors, and their respective employees shall have the right to use, without charge therefor, all light, power and water in the Premises of any Tenant while cleaning or making repairs to or alterations in the Premises of such Tenant.

17. The requirements of Tenants will be attended to by Landlord only upon application at the office of the Building. Employees of Landlord shall not perform any work or do anything outside of their regular duties, unless under special instructions from Landlord.

18. Canvassing, soliciting and peddling in the Building are prohibited, and each Tenant shall cooperate to prevent the same.

19. No Tenant shall cause or permit any unusual or objectionable odors that would annoy other Tenants or create a public or private nuisance to emanate from its Premises. No cooking shall be done in the Premises of any Tenant except as is expressly permitted in such Tenant's lease.

20. Nothing shall be done or permitted in any Tenant's Premises, and nothing shall be brought into or kept in any Tenant's Premises, which would impair or interfere with any of the Building services or the proper and economic heating, cleaning or other servicing of the Building or the Tenant's Premises, or the use or enjoyment by any other Tenant of any other Premises, nor shall there be installed by any Tenant any ventilating, air-conditioning, electrical or other equipment of any kind which, in the reasonable judgment of Landlord, might cause any such impairment or interference.

21. No acids, vapors or other materials which may damage the waste lines, vents or flues of the Building shall be discharged or permitted to be discharged into such waste lines, vents of flues. The water and wash closets and other plumbing fixtures in or serving any Tenant's Premises shall not be used for any purpose other than the purposes for which they were designed or constructed, and no sweeping, rubbish, rags, acids or other foreign substances shall be deposited therein. All damages resulting from any misuse of the fixtures shall be borne by the Tenants who, or whose servants, employees, agents, visitors or licensees shall have cause the same. Any cuspidors or containers or receptacles used as such in the Premises of any tenant or for garbage or similar refuse, shall be emptied, cared for and cleaned by and at the expense of such Tenant.

22. All entrance doors in each Tenant's Premises shall be left locked and all windows shall be left closed by the Tenant when the Tenant's Premises are not in use. Entrance doors to each Tenant's Premises and to the Building shall not be left open at any time. Each Tenant, before closing and leaving its Premises at any time, shall turn out all lights.

23. All windows in each Tenant's Premises shall be kept closed, and all blinds therein above the ground floor shall be lowered as reasonably required because of the position of the sun, during the operation of the Building air-conditioning system to cool or ventilate the Tenant's Premises. If Landlord shall elect to install any energy-saving film on the windows of the Premises or to install energy-saving windows in place of the present windows, each Tenant shall cooperate with the reasonable requirements of Landlord in connection with such installation and permit Landlord or its agents to have access to the Tenant's Premises at reasonable times during business hours to perform such work.

24. No Tenant shall install any resilient tile or similar floor covering in such Tenant's Premises except in such manner as may be approved by the Landlord.

25. No Tenant, or any employee of any Tenant, shall go upon the roof of the Building without the written consent of Landlord.

26. No attachment shall be made to the electric-lighting wires of the Building for the storing of electricity or for the running of motors or other purposes, nor shall any Tenant use any other method of heating than that provided by Landlord, without the written consent of Landlord. No mechanic shall be allowed to work on the Building other than those employed by the Landlord, without the prior written consent of Landlord.

27. Landlord reserves the right to rescind, alter or waiver any rule or regulation at any time prescribed for the Building when, in its reasonable judgment, Landlord deems it necessary, desirable or proper for its best interest and for the best interests of the Tenants generally, and no alteration or waiver of any rule or regulation in favor of one Tenant shall operate as an alteration or waiver in favor of any other Tenant. Landlord shall not be responsible to any Tenant for the non-observance or violation of any of the rules and regulations at any time prescribed for the Building.

28. Landlord reserves the right to amend or add to these Rules and Regulations at any time, provided that Landlord shall furnish to each Tenant a copy of such amended or additional Rules.

29. The Tenant will not, or will he allow his employees to, store vehicles of any type in the parking area or for the purpose of offering them for sale. Advertising of vehicles, boats, trailers, or articles of any kind is prohibited.

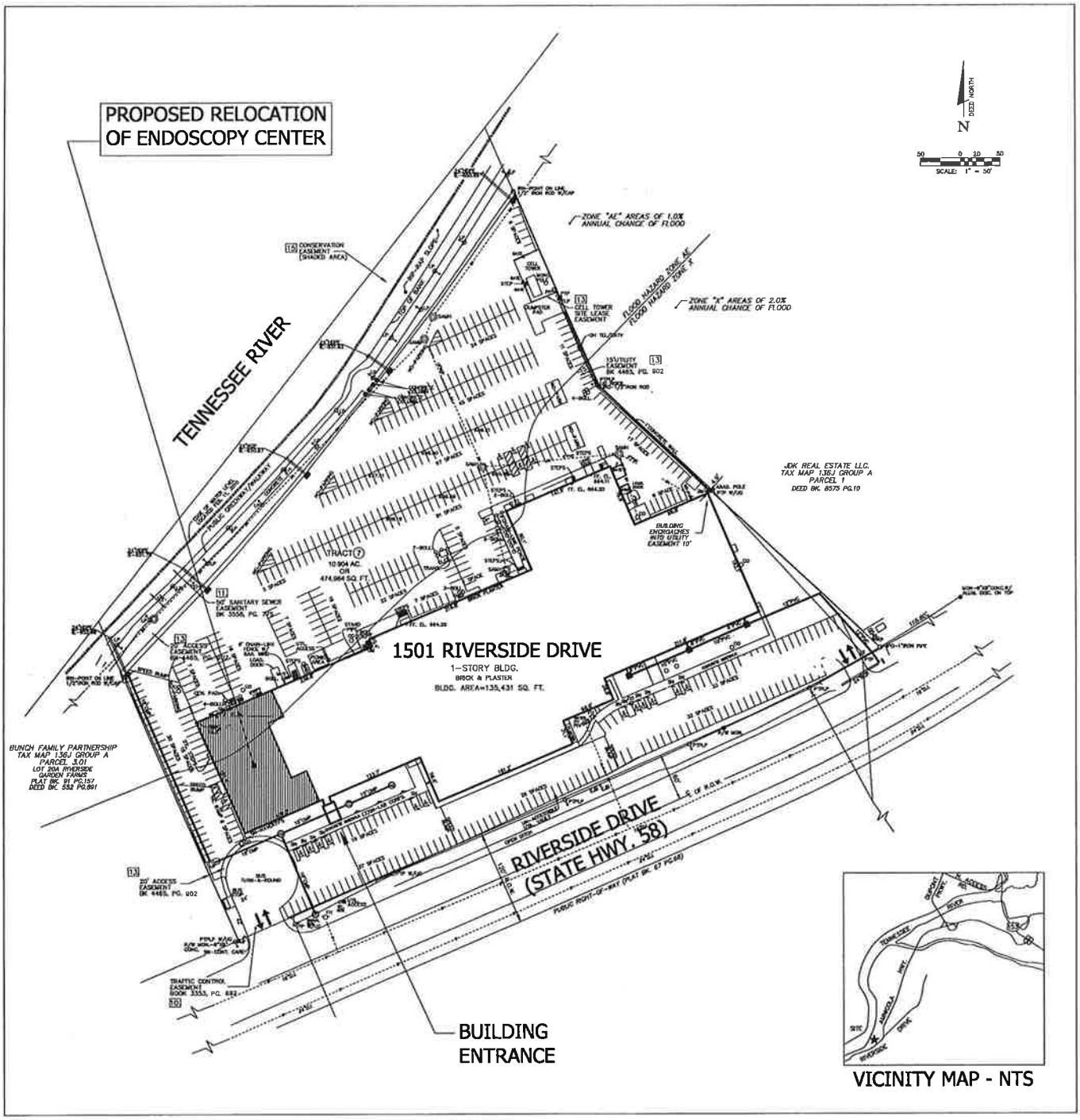
30. No smoking shall be permitted within the premises of any Tenant or the Building. Smoking shall be permitted only in the designated smoking areas.

B.II.A.--Square Footage and Costs Per Square Footage Chart

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost / SF		
					Renovated	New	Total	Renovated	New	Total
Public Reception/Wait				1st	1,439		1,439	$150.00		$215,850.00
Business Office				1st	767		767	$150.00		$115,050.00
Pre-Op				1st	3,058		3,058	$255.00		$779,790.00
Post-Op				1st	3,709		3,709	$255.00		$945,795.00
Support				1st	1,737		1,737	$150.00		$260,550.00
Procedure RMs/Corridor				1st	2,632		2,632	$255.00		$671,160.00
B. Unit/Dept. GSF Sub-Total				1st	13,342		13,342	$223.97		$2,988,207.74
C. Mechanical / Electrical GSF				mezzanine	4,010		4,010	$112.87		$452,608.70
D. Circulation / Structure GSF				1st	158		158	$150.00		$23,700.00
E. Total GSF					17,510		17,510	$197.86		$3,464,500.00

B.III.--Plot Plan



N

Digestive Disorders Endoscopy Center Relocation

HMK ARCHITECTS PLLC

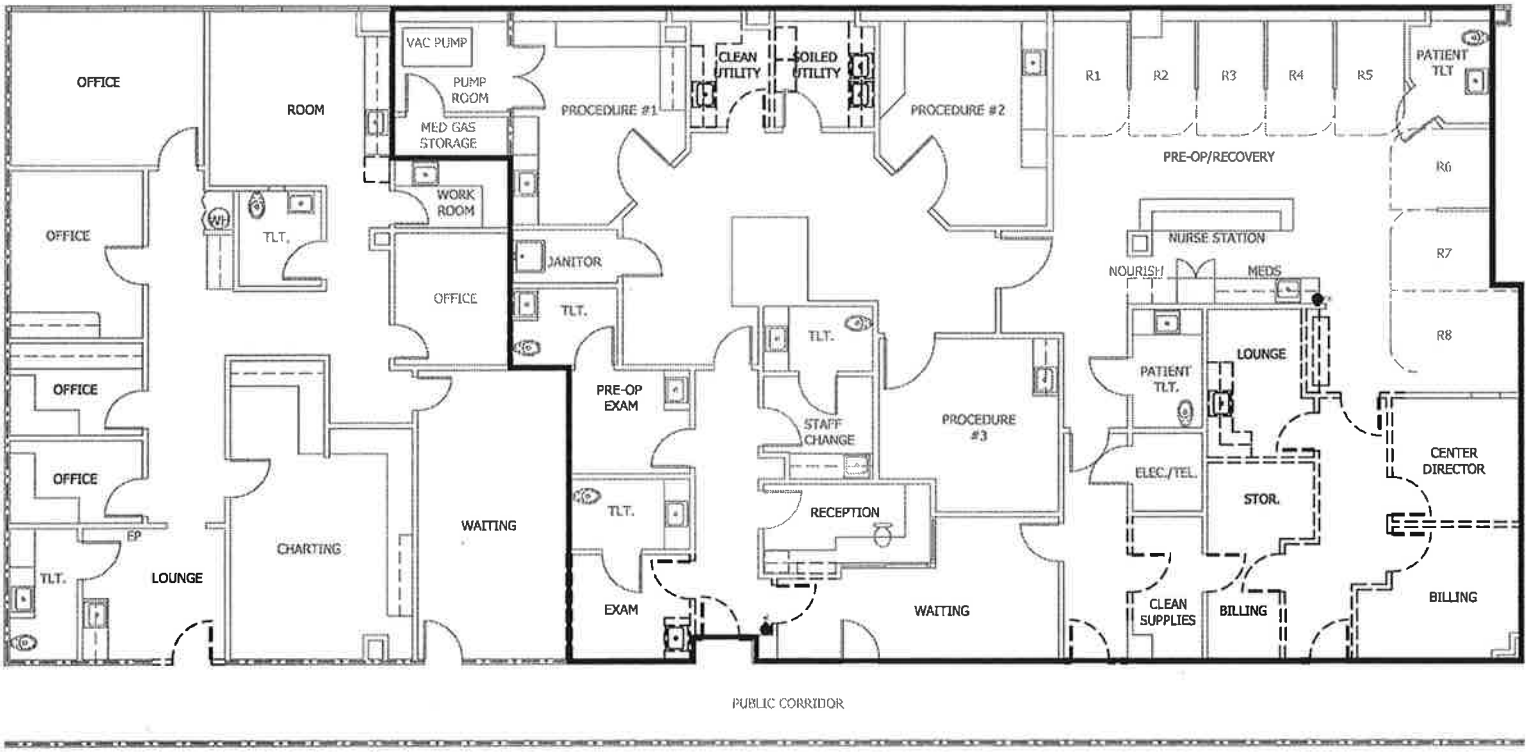
JUNE 4, 2015 - EXISTING PLAN

NOT FOR CONSTRUCTION

PLOT PLAN

NOT TO SCALE

B.IV.--Floor Plan



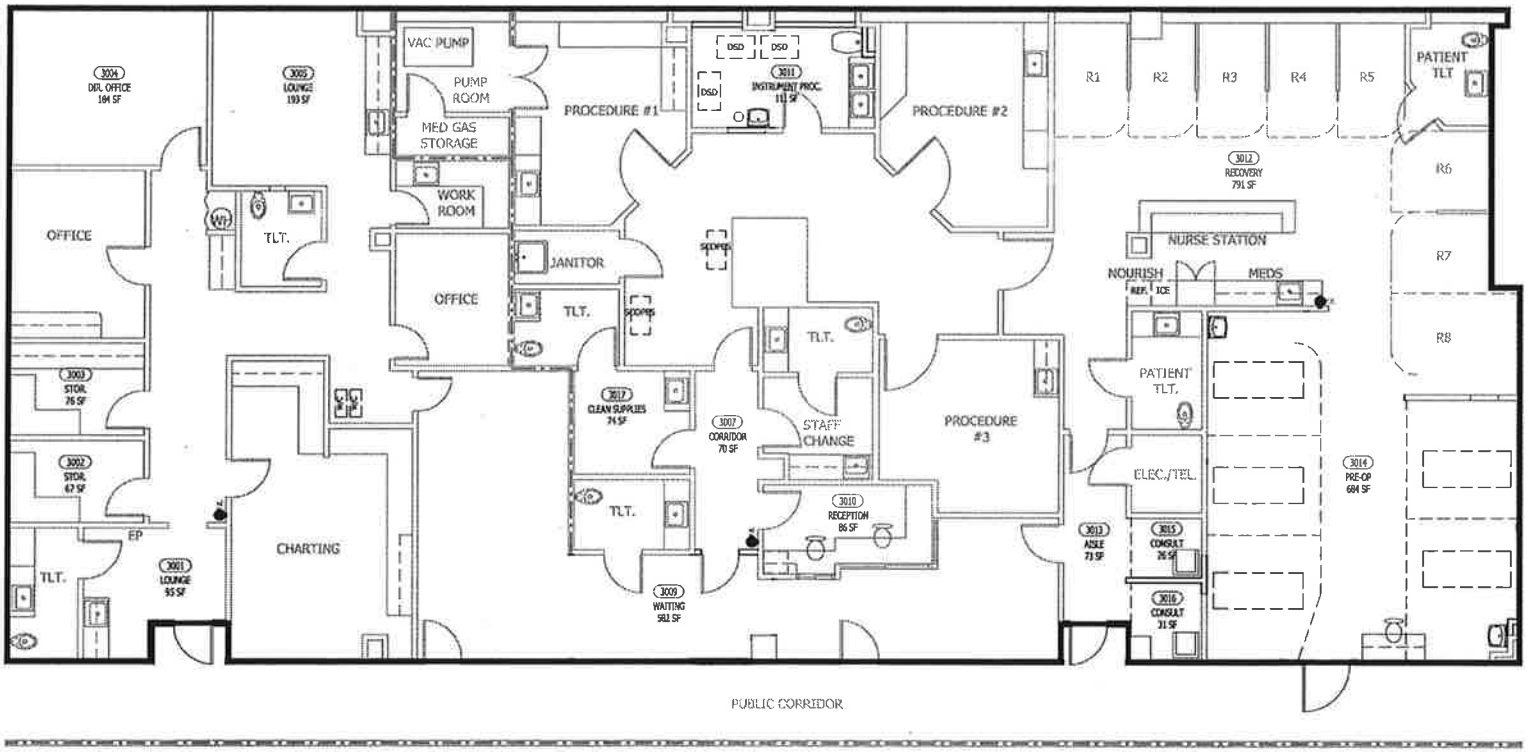
DIGESTIVE DISORDERS ENDOSCOPY CENTER

HMK ARCHITECTS PLLC

APRIL 10, 2015 - EXISTING PLAN 8 Pre- and Post-Op Spaces

NOT FOR CONSTRUCTION

4,022 USABLE SF



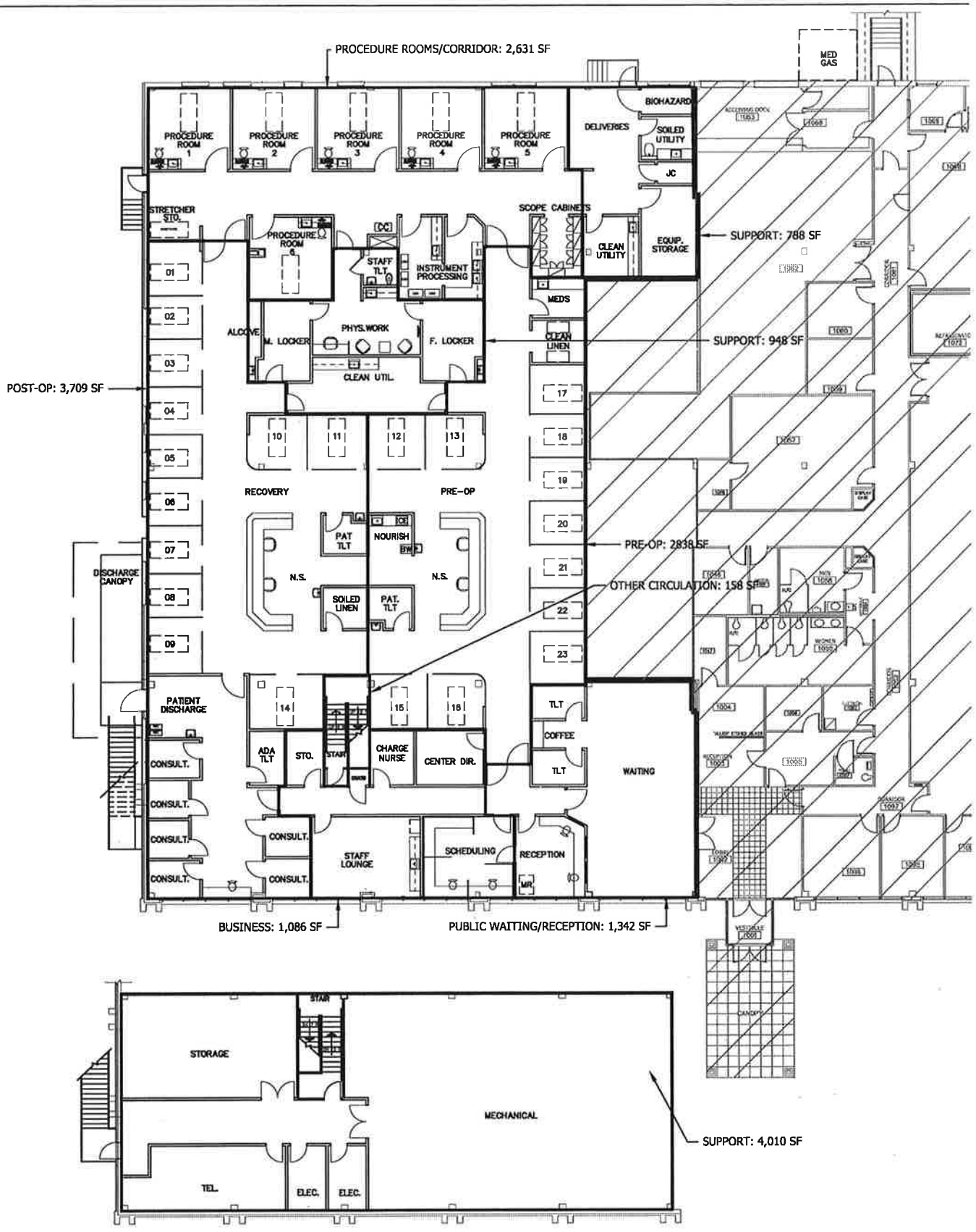
DIGESTIVE DISORDERS ENDOSCOPY CENTER

HMK ARCHITECTS PLLC

APRIL 10, 2015 - PROPOSED PLAN 13 Pre- and Post-Op $paces

NOT FOR CONSTRUCTION

5,790 EXPANDED SF



Digestive Disorders Endoscopy Center Relocation

HMK ARCHITECTS PLLC

JUNE 4, 2015 - PROPOSED PLAN

NOT FOR CONSTRUCTION

17,510 USABLE SF

NOT TO SCALE

C, Need--1.A
Documentation of Project-Specific Criteria

AMSURG

1A Burton Hills Boulevard Nashville, Tennessee 37215 PHONE 615.665.1283 FAX 615.665.0755 www.amsurg.com

AmSurg Chattanooga Anesthesia, LLC
2341 McCallie Avenue , Suite 303
Chattanooga , TN 37404-3237

To Whom It May Concern:

AmSurg Chattanooga Anesthesia, LLC, currently holds individual contracts with eleven (11) Certified Registered Nurse Anesthetists. Additionally, AmSurg Chattanooga Anesthesia, LLC, is under contract with Digestive Disorders Endoscopy Center to provide anesthesia services utilizing one of the eleven contracted providers each day of operation, for each room in operation. AmSurg Chattanooga Anesthesia, LLC, is operating under full intent to continue provision of services to Digestive Disorders Endoscopy Center and will remain contracted with all relevant US and Tennessee-based government payers including TennCare, Medicare, Medicaid and other government-based insurers.

If additional information is needed, please contact Angela Durham, Associate Vice President, Anesthesia Operations, AmSurg, at adurham@amsurg.com or 615-240-3784.

Sincerely,

Angela Durham

Angela Durham
Associate Vice President
AmSurg Anesthesia

Find Shortage Areas: MUA/P by State and County

Shortage Designation Home
Find Shortage Areas
HPSA & MUA/P by Address
HPSA by State & County
HPSA Eligible for the Medicare Physician Bonus Payment

Criteria:
State: Tennessee
County: Hamilton County
ID #: All

Results: 16 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Hamilton County					
Hamilton Service Area	03244	MUA	56.43	1982/06/03	1994/05/04
CT 0011.00					
CT 0012.00					
CT 0013.00					
CT 0014.00					
CT 0016.00					
CT 0018.00					
CT 0019.00					
CT 0020.00					
CT 0023.00					
CT 0024.00					
CT 0025.00					
CT 0026.00					
CT 0031.00					
CT 0123.00					
CT 0124.00					

NEW SEARCH MODIFY SEARCH CRITERIA

Find Shortage Areas: MUA/P by State and County

Shortage Designation Home
Find Shortage Areas
HPSA & MUA/P by Address
HPSA by State & County
HPSA Eligible for the Medicare Physician Bonus Payment

Criteria:
State: Tennessee
County: Bradley County
ID #: All

Results: 5 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Bradley County					
Cleveland Division Service Area	03253	MUA	43.20	1994/05/12	
MCD (90392) District 3					
MCD (90772) District 5					
MCD (90962) District 6					
MCD (91152) District 7					

NEW SEARCH MODIFY SEARCH CRITERIA

Find Shortage Areas: MUA/P by State and County

Shortage Designation Home
Find Shortage Areas
HPSA & MUA/P by Address
HPSA by State & County
HPSA Eligible for the Medicare Physician Bonus Payment

Criteria:
State: Tennessee
County: Marion County
ID #: All

Results: 1 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Marion County					
MARION SERVICE AREA	03215	MUA	53.30	1978/11/01	

NEW SEARCH MODIFY SEARCH CRITERIA

Find Shortage Areas: MUA/P by State and County

Shortage Designation Home
Find Shortage Areas
HPSA & MUA/P by Address
HPSA by State & County
HPSA Eligible for the Medicare Physician Bonus Payment

Criteria:
State: Georgia
County: Walker County
ID #: All

Results: 3 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Walker County					
Walker Service Area	00736	MUA	57.80	1994/05/20	
CT 0207.00					
CT 0208.00					

NEW SEARCH MODIFY SEARCH CRITERIA

Find Shortage Areas: MUA/P by State and County

Shortage Designation Home
Find Shortage Areas
HPSA & MUA/P by Address
HPSA by State & County
HPSA Eligible for the Medicare Physician Bonus Payment

Criteria:
State: Georgia
County: Catoosa County
ID #: All

Results: 2 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Catoosa County					
Catoosa Springs Service Area	00740	MUA	57.50	1994/05/10	1994/05/10
MCD (90582) Catoosa Springs CCD					

NEW SEARCH MODIFY SEARCH CRITERIA

Digestive Disorders Endoscopy Center
MEDICAL STAFF BYLAWS

ARTICLE III
PROCEDURE FOR PRACTITIONER APPOINTMENT AND REAPPOINTMENT

3.1 General Procedures.

All applications for appointment and reappointment to the Medical Staff shall be in writing on a form endorsed by the Governing Board and shall be signed by the applicant. The application shall contain detailed information concerning the applicant's professional experience and qualifications as required by the Governing Board, and shall include a statement indicating the applicant has read the Medical Staff Bylaws and agrees to abide by the terms thereof for as long as his membership continues.

3.2 Effect of Application.

By filing an application for initial appointment or reappointment, and as long as the Practitioner is a member of the Medical Staff or has clinical privileges, the applicant automatically:

3.2.1 Attests to the correctness and completeness of all information contained therein.

3.2.2 Agrees to update and keep current all information contained in said application packet during the course of the application process and as long as membership on the Medical Staff is maintained.

3.2.3 Agrees to abide by the terms of the Center's Code of Conduct, Bylaws and policies and procedures if granted membership and clinical privileges.

3.2.4 Agrees to maintain an ethical practice and to provide care and supervision to patients utilizing the generally recognized professional level of quality.

3.2.5 Agrees to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned by the Governing Board and the Medical Staff.

3.2.6 Agrees to only request specific clinical privileges for which the applicant is qualified based upon the applicant's education, training, experience, demonstrated competence, references and other relevant information.

3.2.7 Agrees that any material misstatement or omission on any application, or made at any time during the appointment or reappointment process, or after Medical Staff membership and/or clinical privileges have been granted, shall be grounds for immediate denial of the application for appointment or reappointment, or summary suspension and termination of Medical Staff membership and clinical privileges if the misstatement or omission is discovered after the Practitioner is appointed or reappointed.

3.3 Application.

The completed Medical Staff application shall be submitted to the Center Leader or designee and shall include, but not be limited to, the following information:

3.3.1 Copy of state licensures with verification of expiration date and that the license is current and unrestricted.

3.3.2 Current Drug Enforcement Administration (DEA) registration with expiration date.

3.3.3 Copy of current state pharmacy license, if applicable, with verification of expiration date and that the license is current and unrestricted.

3.3.4 Written verification of professional schooling, internship, residency, and/or fellowship.

3.3.5 Past and present hospital and other health care entity affiliations, including evidence of applicable privileges held at such entities.

3.3.6 Memberships in professional associations, societies, academies, colleges, and faculty appointments.

3.3.7 Specialty or board certification status.

3.3.8 Medicare and Medicaid provider numbers, if applicable.

3.3.9 Completed Health Status Assessment Form and documentation of applicable health testing and vaccinations, which shall demonstrate that the applicant is capable of performing the functions of staff membership and exercising the privileges requested.

3.3.10 Information concerning the applicant's current and/or previous participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion. The applicant shall have a continuing duty to notify the Medical Director of the initiation of participation in any rehabilitation or impairment program. The Medical Director shall be responsible for notifying the Medical Executive Committee of all such actions.

3.3.11 Any current criminal charges pending against the applicant and any past convictions or pleas. Practitioner shall notify the Center Leader and Medical Director within seven (7) days of receiving notice of the initiation of any criminal charges, and shall acknowledge the Center's right to perform a background check at appointment, reappointment, and any interim time when reasonable suspicion has been shown.

3.3.12 Any allegations of civil or criminal fraud pending against the applicant and any past allegations including their resolution and any investigations by any private, federal or state agency concerning participation in any health insurance program, including Medicare and Medicaid.

3.3.13 Copy of current professional liability insurance certificate with minimum limits as determined by the Governing Board.

3.3.14 Information regarding professional liability and malpractice claims either filed, pending, settled, or pursued to final judgment.

3.3.15 Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of the following:

3.3.15.1 State licenses or DEA registrations;

3.3.15.2 Membership/fellowship in local, state or national professional organizations.

3.3.15.3 Specialty board certifications;

3.3.15.4 License to practice any profession in any jurisdiction.

3.3.15.5 DEA number/controlled substance license.

3.3.15.6 Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges.

3.3.15.7 Practitioner's management of patients which may have given rise to investigation by the state medical board.

3.3.15.8 Participation in any private, federal or state health insurance program, including Medicare and Medicaid.

The applicant shall have a continuing duty to notify the Center Leader or Medical Director within seven (7) days of receiving notice of the initiation of any of the above actions against him/her. The Center Leader or Medical Director shall be responsible for notifying the Medical Executive Committee of all such actions.

3.3.16 Two (2) letters of professional reference from peers or individuals from the same discipline and with essentially equal qualifications as the applicant, other than family or those affiliated by marriage, who must have personal knowledge of the applicant's recent professional performance, ethical character, current competence, and ability to work cooperatively with others.

3.3.17 Copy of current BLS/ACLS/PALS certification if applicable.

3.3.18 Signed release of liability and attestation.

3.3.19 Proof of completion of state-required continuing medical education for the past two (2) years.

3.3.20 Evidence of privileges held at local hospital and Medical Staff standing, unless such physician practices opthamology, anesthesiology, or pain management and has submitted appropriate documentation as described in Section 2.3.9.

3.3.21 Delineation of Privileges Form indicating the specific clinical privileges for which the applicant wishes to be considered.

3.3.22 Signed statement acknowledging the applicant's understanding of the scope and extent of authorization, confidentiality, immunity, and release provisions of Article IX and agreement to exhaust all administrative remedies afforded by the Medical Staff Bylaws before resorting to formal legal action, should an adverse ruling be made with respect to his or her staff membership and/or clinical privileges.

3.3.23 Signed statement that the applicant has received and read the Medical Staff Bylaws and agrees to be bound by the terms thereof if granted membership and/or clinical privileges, and to be bound by the terms thereof in all matters relating to the consideration of his/her application, without regard to whether or not he/she is granted membership and/or clinical privileges.

3.4 Processing the Initial Application.

3.4.1 Applicant's Burden of Proof. The applicant has the burden of producing all required information deemed adequate as determined by the Center for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts relating to the granting of Medical Staff membership and/or clinical privileges. It is the applicant's responsibility to ensure that the Center receives all required supporting documents verifying information on the application and providing sufficient evidence, as required in the sole discretion of the Center, that the applicant meets the requirements for Medical Staff membership and the privileges requested.

3.4.2 Request for Additional Information. If information is missing from the application, or new, additional or clarifying information is required, a letter requesting such information will be sent to the applicant. If the requested information is not returned to the Center within thirty (30) days of receipt of the request letter, the application is deemed as voluntarily withdrawn.

C, Need--1.A.3.e.
Letters of Intent & Qualifications

CHATTANOOGA
ENDOSCOPY CENTER

June 1, 2015

Jillian P. Wright
Regional Vice President--Operations
1A Burton Hills Boulevard
Nashville, Tennessee 37215

Dear Mrs. Wright:

We, the undersigned, are gastroenterologists who perform endoscopic surgeries in the Chattanooga area. This letter is to support the relocation and expansion of the Chattanooga Endoscopy Center, where we currently have procedure privileges.

We estimate that together we will perform at least 11,442 outpatient endoscopy cases annually in that facility, from the time it opens at its new location. We currently perform more than that number of outpatient cases in area facilities.

Sumeet Bhushan, MD

Munford Yates, MD

Chad Charapata, MD

David N. Collins, MD

Donald Hetzel, MD

Alan Shikoh, MD

Scott Manton, MD

Camille Sommer, MD

Gregory Olds, MD

Henry Paik, MD

Vijay Patel, MD

Richard Sadowitz, MD

Colleen Schmitt, MD

Richard A. Krause, MD

Larry Shuster, MD

American Board of Internal Medicine®

Home | Search results for Name SUMEET BHUSHAN

Search results for Name SUMEET BHUSHAN

November 21, 2014

Bhushan, Sumeet J.

Gastroenterology: **Certified**

Meeting Maintenance of Certification Requirements: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 2000
Gastroenterology: 2003

For more information about ABIM certification and MOC, go to:

MOC Requirements
Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility
Representation of Certification Status
Suspension and Revocation of Certification

Important notes about this page:

- Most diplomates certified prior to 1990 are not required to participate in MOC but are strongly encouraged to do so.
- All ABIM certifications issued in 1990 (1987 for critical care medicine and 1988 for geriatric medicine) and thereafter must be maintained through ABIM's MOC program.
- ABIM's website serves as primary source verification.
- Diplomates are publicly reported as meeting MOC requirements for all certifications as long as they are meeting MOC requirements in one certification area.
- Certification status is updated to this system within 5 days of notification to the physicians. Data elements, such as name changes, are updated in ABIM's records within 24 hours of being processed by ABIM.
- If you do not find your physician or they are listed as not certified, they may be certified by another board of the American Board of Medical Specialties. Please check www.certificationmatters.org. Additionally, information on Allergy and Immunology, Clinical Laboratory Immunology and Diagnostic Laboratory Immunology diplomates can be now found at www.certificationmatters.org.

THE

AMERICAN BOARD OF INTERNAL MEDICINE

INCORPORATED 1936

ATTESTS THAT

Sumeet Jagdish Bhushan

HAS MET THE REQUIREMENTS OF THIS BOARD AND IS HEREBY CERTIFIED FOR THE PERIOD 2013 THROUGH 2023 AS A DIPLOMATE IN

GASTROENTEROLOGY

CHAIR
AMERICAN BOARD OF INTERNAL MEDICINE

CHAIR-ELECT
AMERICAN BOARD OF INTERNAL MEDICINE

PRESIDENT
AMERICAN BOARD OF INTERNAL MEDICINE

SECRETARY
AMERICAN BOARD OF INTERNAL MEDICINE

TREASURER
AMERICAN BOARD OF INTERNAL MEDICINE

COUNCIL CHAIR
AMERICAN BOARD OF INTERNAL MEDICINE

SUBSPECIALTY BOARD ON GASTROENTEROLOGY

CHAIR

Kenneth R. McQuaid

Deborah Denise Proctor

J. Rogerdor Ryddy

James M. Scheman

NUMBER 198347

2013

American Board of Internal Medicine®

Search results for Name CHAD MICHAEL CHARAPATA Date of Birth 09/26/73

December 4, 2014

Charapata, Chad M.

Gastroenterology: **Certified**

Meeting Maintenance of Certification Requirements: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 2003
Gastroenterology: 2006

For more information about ABIM certification and MOC, go to:

MOC Requirements
Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility
Representation of Certification Status
Suspension and Revocation of Certification

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American Board of Internal Medicine®

November 21, 2014

Collins, David N.

Gastroenterology: **Certified**
Internal Medicine: **Certified**

Meeting Maintenance of Certification Requirements: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1981
Gastroenterology: 1983

For more information about ABIM certification and MOC, go to:

MOC Requirements
Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility
Representation of Certification Status
Suspension and Revocation of Certification

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American Board of Internal Medicine®

Home | Search results for Name DONALD HETZEL

Search results for Name DONALD HETZEL

December 4, 2014

Hetzel, Donald P.

Gastroenterology: **Certified**
Internal Medicine: **Certified**

Meeting Maintenance of Certification Requirements: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1987
Gastroenterology: 1993

For more information about ABIM certification and MOC, go to:

MOC Requirements
Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility
Representation of Certification Status
Suspension and Revocation of Certification

Important notes about this page:

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American Board of Internal Medicine®

May 20, 2015

Krause, Richard A.

Gastroenterology: **Certified**
Internal Medicine: **Certified**

Participating in Maintenance of Certification: **No**

INITIAL CERTIFICATION
Internal Medicine: 1975
Gastroenterology: 1981

Important information regarding the physician verification tool:

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MOC Requirements
Annual Reverification Date – April 1st
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Board Eligibility
Representation of Certification Status

Digestive Disorders Endoscopy Center

American Board of Internal Medicine

Search results for Name JAMES SCOTT MANTON Date of Birth 05/05/69

December 4, 2014

Manton, James S.

Gastroenterology: **Certified**

Meeting Maintenance of Certification Requirements: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1998
Gastroenterology: 2002

For more information about ABIM certification and MOC, go to:

MOC Requirements
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THE AMERICAN BOARD OF INTERNAL MEDICINE

INCORPORATED 1936

ATTESTS THAT

James Scott Manton

HAS MET THE REQUIREMENTS OF THIS BOARD AND IS HEREBY CERTIFIED FOR THE PERIOD 2012 THROUGH 2022

AS A DIPLOMATE IN

GASTROENTEROLOGY

CHAIR
AMERICAN BOARD OF INTERNAL MEDICINE

CHAIR-ELECT
AMERICAN BOARD OF INTERNAL MEDICINE

SECRETARY-TREASURER
AMERICAN BOARD OF INTERNAL MEDICINE

PRESIDENT
AMERICAN BOARD OF INTERNAL MEDICINE

SUBSPECIALTY BOARD ON GASTROENTEROLOGY

CHAIR

NUMBER 185436

2012

American Board of Internal Medicine®

Home | Search results for Name GREGORY OLDS

Search results for Name GREGORY OLDS

May 20, 2015

Olds, Gregory D.

Gastroenterology: **Certified**

Participating in Maintenance of Certification: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1999
Gastroenterology: 2004

Search again

Name ABIM ID NPI #

First (if known): GREGORY
Middle (if known):
Last (required): OLDS
DOB (if known): mm/dd/yy format
(•) Match Exactly ( ) Is Similar
(•) Show All ( ) Show 20
Go

Check a physician's ABIM Board Certification status by searching name, ABIM ID or NPI# by using the verification tool (at top right).

Important information regarding the physician verification tool:

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Annual Reverification Date – April 1st
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Board Eligibility
Representation of Certification Status

American Board of Internal Medicine®

Home | Search results for Name HENRY PAIK

Search results for Name HENRY PAIK

ABIM leaders announced significant changes to the MOC program on 2/3/15, including suspension of some requirements. Therefore, some diplomates who are listed as "not certified" may be certified. And some diplomates may have certifications that are not listed on this page. We apologize for the inconvenience and we will have this page corrected as soon as possible.

Search again

Name ABIM ID NPI#

First (if known): HENRY
Middle (if known):
Last (required): PAIK
DOB (if known): mm/dd/yy format
Match Exactly / Is Similar
Show All / Show 20
Go

March 17, 2015

Paik, Henry K.

Gastroenterology: **Certified**

Meeting Maintenance of Certification Requirements: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1993
Gastroenterology: 1995

Check a physician's ABIM Board Certification status by searching name, ABIM ID or NPI# by using the verification tool (at top right).

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American Board of Internal Medicine®

Home | Search results for NPI No. 1558343434

Search results for NPI No. 1558343434

December 4, 2014

Patel, Vijaykumar P.

Gastroenterology: **Certified**
Internal Medicine: **Certified**

Meeting Maintenance of Certification Requirements: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1989
Gastroenterology: 1991

For more information about ABIM certification and MOC, go to:

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American Board of Internal Medicine®

May 20, 2015

Sadowitz, Richard H.

Gastroenterology: **Certified**

Participating in Maintenance of Certification: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1991
Gastroenterology: 1998

Important information regarding the physician verification tool:

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American Board of Internal Medicine®

November 21, 2014

Schmitt, Colleen M.

Gastroenterology: **Certified**
Internal Medicine: **Certified**

Meeting Maintenance of Certification Requirements: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1989
Gastroenterology: 1993

For more information about ABIM certification and MOC, go to:

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KBRW

11/21/2014

American Board of Internal Medicine®

Home | Search results for Name ALAN SHIKOH

Search results for Name ALAN SHIKOH

November 21, 2014

Shikoh, Alan F.

Gastroenterology: **Certified**

Meeting Maintenance of Certification Requirements: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1995
Gastroenterology: 1997

For more information about ABIM certification and MOC, go to:

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THE

AMERICAN BOARD OF INTERNAL MEDICINE

INCORPORATED 1936

ATTESTS THAT

Larry David Shuster, M.D.

HAS MET THE REQUIREMENTS OF THIS BOARD AND IS HEREBY DESIGNATED A DIPLOMATE CERTIFIED IN THE SUBSPECIALTY OF

GASTROENTEROLOGY

CHAIRMAN
AMERICAN BOARD OF INTERNAL MEDICINE

CHAIRMAN-ELECT
AMERICAN BOARD OF INTERNAL MEDICINE

SECRETARY-TREASURER
AMERICAN BOARD OF INTERNAL MEDICINE

SUBSPECIALTY BOARD ON GASTROENTEROLOGY

CHAIRMAN

NUMBER 105044

DATE NOVEMBER 7, 1969

FORM

American Board of Internal Medicine®

510 Walnut Street · Suite 1700 Philadelphia, PA | 19106-3699 . 800.441.2246 | www.abim.org | request@abim.org

October 7, 2013

Dr. Camille Anne Sommer
~~3207 Inverness Cliffs~~
Birmingham, AL 35242-3745

ABIM ID: 297447

Dear Dr. Sommer:

Congratulations! I am pleased to inform you that you passed the American Board of Internal Medicine (ABIM) 2013 Internal Medicine Certification Examination . Our website, www.abim.org, has been updated to indicate that you are ABIM Board Certified.

The following information is enclosed:

- Your Score Report
- Description of the Score Report
- Form to order your certificate(s)
- Guidelines for stating your ABIM Board Certification status

ABIM will provide your name to the American Board of Medical Specialties (ABMS) for listing in *The Official ABMS Directory of Board Certified Medical Specialists*. ABMS will send you a form soliciting the information to appear in your listing.

I would also like to welcome you to ABIM's Maintenance of Certification (MOC) program. MOC is a continuous process whereby diplomates engage in ongoing self-assessment activities. In early 2014, you will be issued a certificate, the ongoing validity of which is contigent upon "Meeting MOC Requirements" (i.e., continuously engaging in MOC activities).

Because you are newly certified, your 2014 MOC fee will be waived and you will be Meeting MOC Requirements in January. To continue to be Meeting MOC Requirements, you will need to go to your Physician Login on abim.org by March 31, 2014 and indicate that you intend to maintain your Internal Medicine certification, and your waiver will be applied. Please review the enclosed information and visit moc2014.abim.org for an overview of the MOC program requirements and how to get started.

You are also eligible to claim *AMA PRA Category 1 Credits*™ directly from the AMA for earning your certification. As documentation of your ABIM Board Certification, the AMA will require either a copy of this letter or a copy of your new ABIM certificate. For details go to www.abim.org/certification and choose "Claim CME Credit."

Note the e-mail is the primary means through which ABIM will communicate with you. Please notify us immediately of any changes to your e-mail or mailing address by updating your contact information at www.abim.org.

If you have questions, please call 1 (800) 441-ABIM (2246). Mon. - Fri., 8:30 a.m. to 8 p.m. ET, Sat., 9 a.m. to 12 p.m. ET, or e-mail us at request@abim.org.

On behalf of ABIM, I wish you continued success and enrichment throughout your career.

Respectfully,

Richard J. Baron, MD, MACP
President and CEO

American Board of Internal Medicine®

Home | Search results for NPI No. 1104892017

Search results for NPI No. 1104892017

December 4, 2014

Yates, Munford R.

Gastroenterology: **Certified**

Meeting Maintenance of Certification Requirements: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1997
Gastroenterology: 2000

For more information about ABIM certification and MOC, go to:

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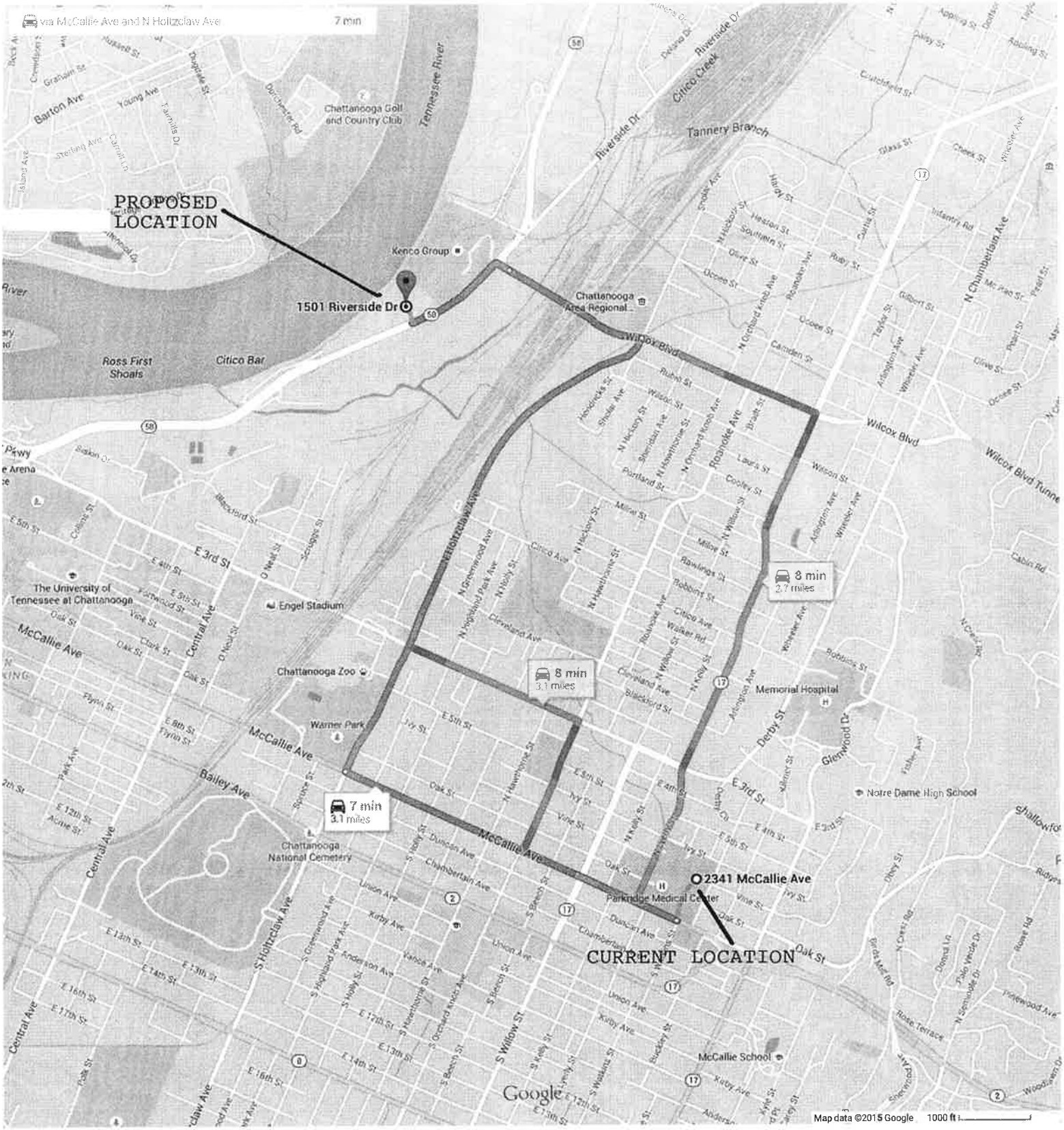
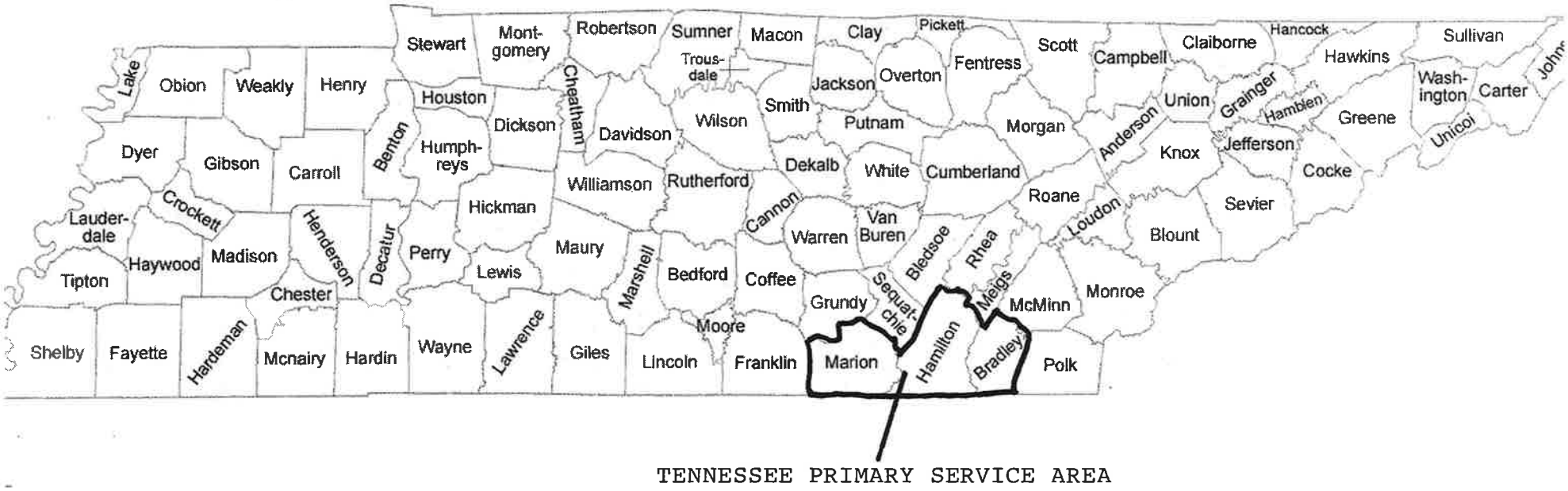
C, Need--3
Service Area Maps


via McCallie Ave and N Holtzclaw Ave
7 min
PROPOSED LOCATION
1501 Riverside Dr
Kenco Group
Chattanooga Area Regional...
Wilcox Blvd
Wilcox Blvd Tunne
Tannery Branch
Citico Creek
Riverside Dr
Tennessee River
Chattanooga Golf and Country Club
Ross First Shoals
Citico Bar
Roanoke Ave
N Holtzclaw Ave
E 3rd St
McCallie Ave
Bailey Ave
Central Ave
The University of Tennessee at Chattanooga
Engel Stadium
Chattanooga Zoo
Warner Park
Chattanooga National Cemetery
Memorial Hospital
Parkridge Medical Center
Notre Dame High School
McCallie School
Derby St
Glenwood Dr
S Willow St
8 min
2.7 miles
8 min
3.1 miles
7 min
3.1 miles
2341 McCallie Ave
CURRENT LOCATION
Google
Map data ©2015 Google
1000 ft


Lake
Obion
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Henry
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Sumner
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Scott
Campbell
Claiborne
Hancock
Hawkins
Sullivan
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Cheatham
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Davidson
Wilson
Smith
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Williamson
Rutherford
Dekalb
White
Cumberland
Anderson
Knox
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Cocke
Unicoi
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Hickman
Cannon
Roane
Sevier
Lauder-
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Henderson
Decatur
Perry
Maury
Warren
Van
Buren
Bledsoe
Rhea
Loudon
Blount
Haywood
Madison
Lewis
Marshall
Bedford
Coffee
Sequat-
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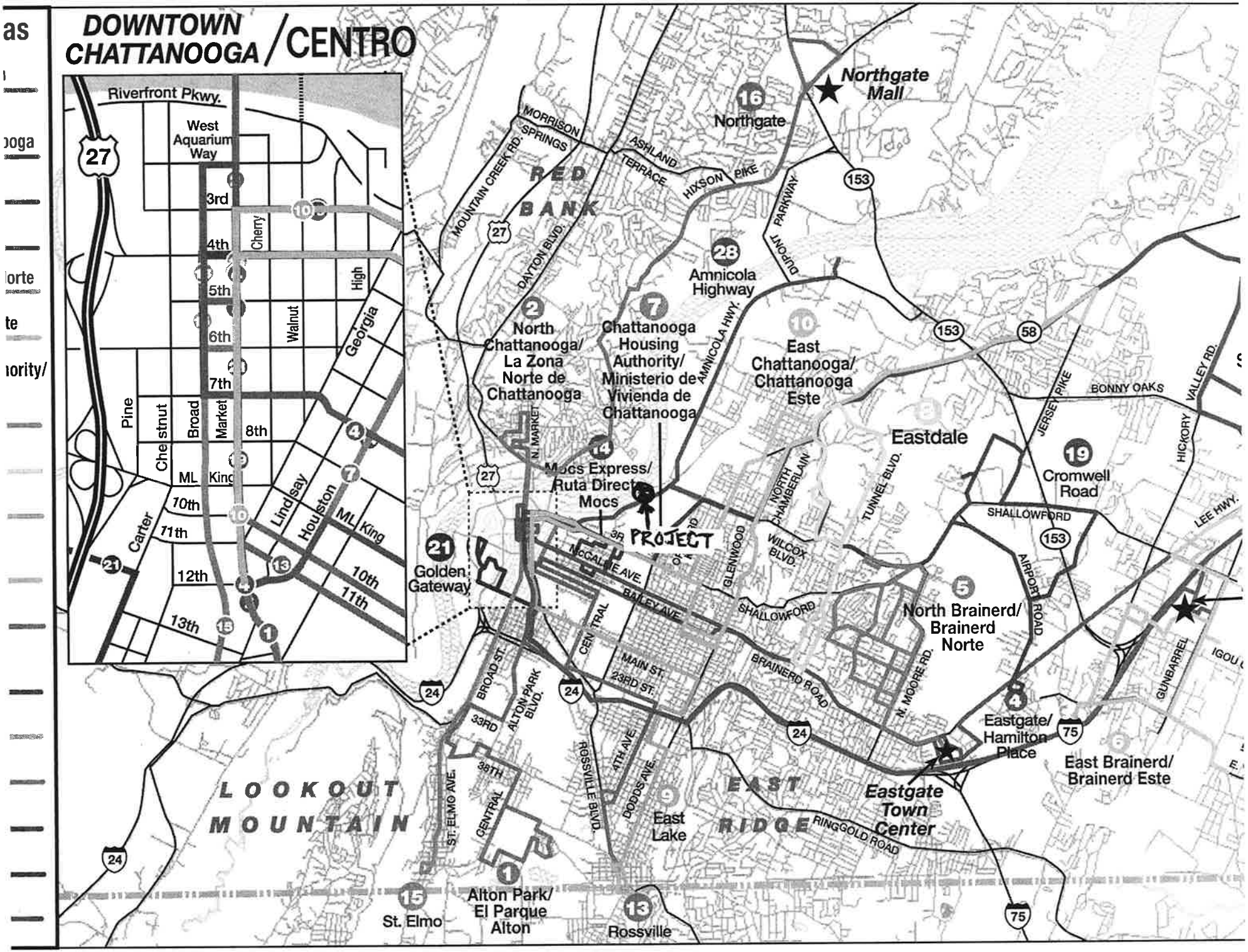
Meigs
Tipton
Chester
Grundy
McMinn
Monroe
Shelby
Fayette
Hardeman
Mcnairy
Hardin
Wayne
Lawrence
Giles
Lincoln
Moore
Franklin
Marion
Hamilton
Bradley
Polk
TENNESSEE PRIMARY SERVICE AREA


GEORGIA PRIMARY SERVICE AREA
Dade
Catoosa
Fannin
Towns
Union
Rabun
Murray
Whitfield
Walker
Gilmer
White
Habersham
Stephens
Lumpkin
Chattooga
Gordon
Pickens
Dawson
Hall
Banks
Franklin
Hart
Floyd
Bartow
Cherokee
Forsyth
Jackson
Madison
Elbert
Polk
Cobb
Barrow
Clarke
Oglethorpe
Paulding
Gwinnett
Oconee
Haralson
Douglas
Fulton
Dekalb
Walton
Wilkes
Lincoln
Rockdale
Carroll
Clayton
Newton
Morgan
Greene
Taliaferro
Columbia
Mcduffie
Fayette
Henry
Warren
Heard
Coweta
Spalding
Butts
Jasper
Putnam
Hancock
Richmond
Glascock
Meriwether
Pike
Lamar
Monroe
Jones
Baldwin
Jefferson
Burke
Troup
Upson
Washington
Bibb
Wilkinson
Jenkins
Harris
Talbot
Crawford
Twiggs
Johnson
Screven
Emanuel
Muscogee
Taylor
Peach
Houston
Bleckley
Laurens
Treutlen
Candler
Bulloch
Effingham
Chatta-
hoochee
Marion
Macon
Schley
Dooly
Pulaski
Dodge
Wheeler
Mont-
gomery
Toombs
Evans
Bryan
Chatham
Stewert
Webster
Sumter
Wilcox
Telfair
Tattnall
Crisp
Quitman
Terrell
Lee
Turner
Benhill
Jeff
Davis
Appling
Liberty
Long
Randolph
Clay
Calhoun
Dougherty
Worth
Irwin
Coffee
Bacon
Wayne
Mcintosh
Tift
Early
Baker
Berrien
Atkinson
Pierce
Glynn
Mitchell
Colquitt
Ware
Brantley
Miller
Cook
Seminole
Lanier
Clinch
Charlton
Camden
Decatur
Grady
Thomas
Brooks
Lowndes
Echols


DOWNTOWN CHATTANOOGA / CENTRO
Riverfront Pkwy.
West Aquarium Way
3rd
4th
5th
6th
7th
8th
10th
11th
12th
13th
ML King
Cherry
High
Walnut
Georgia
Pine
Chestnut
Broad
Market
Lindsay
Houston
Carter
27
Northgate Mall
16 Northgate
MORRISON SPRINGS
ASHLAND TERRACE
HIXSON PIKE
MOUNTAIN CREEK RD.
DAYTON BLVD.
RED BANK
DUPONT PARKWAY
153
28 Amnicola Highway
AMNICOLA HWY.
2 North Chattanooga/ La Zona Norte de Chattanooga
7 Chattanooga Housing Authority/ Ministerio de Vivienda de Chattanooga
10 East Chattanooga/ Chattanooga Este
58
JERSEY PIKE
BONNY OAKS
VALLEY RD.
HICKORY
Eastdale
19 Cromwell Road
SHALLOWFORD
LEE HWY.
N. MARKET
14 Mocs Express/ Ruta Directa Mocs
PROJECT
NORTH CHAMBERLAIN
TUNNEL BLVD.
GLENWOOD
WILCOX BLVD.
21 Golden Gateway
McCALLIE AVE.
BAILEY AVE.
CENTRAL
MAIN ST.
23RD ST.
BRAINERD ROAD
5 North Brainerd/ Brainerd Norte
AIRPORT ROAD
N. MOORE RD.
GUNBARREL
4 Eastgate/ Hamilton Place
75
6 East Brainerd/ Brainerd Este
BROAD ST.
ALTON PARK BLVD.
33RD
38TH
CENTRAL
ST. ELMO AVE.
ROSSVILLE BLVD.
4TH AVE.
DODDS AVE.
9 East Lake
EAST RIDGE
Eastgate Town Center
RINGGOLD ROAD
LOOKOUT MOUNTAIN
24
15 St. Elmo
1 Alton Park/ El Parque Alton
13 Rossville

C, Economic Feasibility--1
Documentation of Construction Cost Estimate

HMK
ARCHITECTS PLLC

May 15, 2015

Ms. Melanie Hill
Executive Director
State of Tennessee
Health Services and Development Agency
500 Deadrick Street, Suite 850
Nashville, TN 37243

RE: Digestive Disorders Endoscopy Center – Chattanooga, TN
Endoscopy Center Relocation – Verification of Construction Cost

Dear Ms. Hill:

We have reviewed the construction cost developed for the endoscopy center relocation project for Digestive Disorders Endoscopy Center. The construction cost of $3,464,500.00 is based on 13,500 usable square feet of renovation to an existing facility.

It is our professional opinion that the construction cost proposed is consistent with historical data based on our experience with similar type projects. It is important to note, that our opinion is based on normal market conditions, price escalation, etc.

The project will be developed under the current codes and standards enforced by the State of Tennessee as follows:

2012 International Building Code/2012 International Mechanical Code/2012 International Plumbing Code
2012 International Gas Code
2011 National Electrical Code
2012 NFPA 1, excluding NFPA 5000
2012 NFPA 101, Life Safety Code
2010 FGI Guidelines for the Design and Construction of Health Care Facilities
2002 North Carolina Accessibility Code with 2004 Amendments
2010 Americans with Disabilities Act (ADA)

Sincerely,

HMK ARCHITECTS PLLC

Donald C. Miller, NCARB, AIA – [TN License No. 100019]

C, Economic Feasibility--2
Documentation of Availability of Funding

AMSURG

1A Burton Hills Boulevard
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June 1, 2015

Melanie M. Hill, Executive Director
Tennessee Health Facilities Commission
Andrew Jackson State Office Building, Ninth Floor
500 Deaderick Street
Nashville, Tennessee 37243

Dear Mrs. Hill:

The Chattanooga Endoscopy Center (formerly the Digestive Disorders Endoscopy Center) is an existing single-specialty ASTC limited to endoscopy. It is owned by The Chattanooga Endoscopy ASC, LLC, whose members are AmSurg Holdings and twelve Chattanooga gastroenterologists.

The facility is filing a Certificate of Need application to move to a new location in Chattanooga. The actual capital cost of the project is estimated at approximately $5,900,000.

As Chief Financial Officer of AmSurg, I am writing to confirm that AmSurg Corp. will provide all of the required funding for the project in the form of a loan to the applicant LLC. The Certificate of Need application includes the company's financial statements documenting that sufficient cash reserves, operating income, and lines of credit exist to provide that funding.

Sincerely,

Claire Gulmi
Chief Financial Officer and Executive Vice President

2063-Chattanooga GI-$5.9 million-AMSURG-ESTIMATE

Compound Period ..... : Monthly

Nominal Annual Rate .... : 5.000 %

CASH FLOW DATA

	Event	Date	Amount	Number	Period	End Date
1	Loan	01/01/2017	5,900,000.00	1		
2	Payment	02/01/2017	Interest Only	12	Monthly	01/01/2018
3	Payment	02/01/2018	111,340.28	60	Monthly	01/01/2023

AMORTIZATION SCHEDULE - Normal Amortization

	Date	Payment	Interest	Principal	Balance
Loan	01/01/2017				5,900,000.00
1	02/01/2017	24,583.33	24,583.33	0.00	5,900,000.00
2	03/01/2017	24,583.33	24,583.33	0.00	5,900,000.00
3	04/01/2017	24,583.33	24,583.33	0.00	5,900,000.00
4	05/01/2017	24,583.33	24,583.33	0.00	5,900,000.00
5	06/01/2017	24,583.33	24,583.33	0.00	5,900,000.00
6	07/01/2017	24,583.33	24,583.33	0.00	5,900,000.00
7	08/01/2017	24,583.33	24,583.33	0.00	5,900,000.00
8	09/01/2017	24,583.33	24,583.33	0.00	5,900,000.00
9	10/01/2017	24,583.33	24,583.33	0.00	5,900,000.00
10	11/01/2017	24,583.33	24,583.33	0.00	5,900,000.00
11	12/01/2017	24,583.33	24,583.33	0.00	5,900,000.00
2017 Totals		270,416.63	270,416.63	0.00	
12	01/01/2018	24,583.33	24,583.33	0.00	5,900,000.00
13	02/01/2018	111,340.28	24,583.33	86,756.95	5,813,243.05
14	03/01/2018	111,340.28	24,221.85	87,118.43	5,726,124.62
15	04/01/2018	111,340.28	23,858.85	87,481.43	5,638,643.19
16	05/01/2018	111,340.28	23,494.35	87,845.93	5,550,797.26
17	06/01/2018	111,340.28	23,128.32	88,211.96	5,462,585.30
18	07/01/2018	111,340.28	22,760.77	88,579.51	5,374,005.79
19	08/01/2018	111,340.28	22,391.69	88,948.59	5,285,057.20
20	09/01/2018	111,340.28	22,021.07	89,319.21	5,195,737.99
21	10/01/2018	111,340.28	21,648.91	89,691.37	5,106,046.62
22	11/01/2018	111,340.28	21,275.19	90,065.09	5,015,981.53
23	12/01/2018	111,340.28	20,899.92	90,440.36	4,925,541.17
2018 Totals		1,249,326.41	274,867.58	974,458.83	
24	01/01/2019	111,340.28	20,523.09	90,817.19	4,834,723.98
25	02/01/2019	111,340.28	20,144.68	91,195.60	4,743,528.38
26	03/01/2019	111,340.28	19,764.70	91,575.58	4,651,952.80
27	04/01/2019	111,340.28	19,383.14	91,957.14	4,559,995.66
28	05/01/2019	111,340.28	18,999.98	92,340.30	4,467,655.36
29	06/01/2019	111,340.28	18,615.23	92,725.05	4,374,930.31
30	07/01/2019	111,340.28	18,228.88	93,111.40	4,281,818.91

2063-Chattanooga GI-$5.9 million-AMSURG-ESTIMATE

	Date	Payment	Interest	Principal	Balance
31	08/01/2019	111,340.28	17,840.91	93,499.37	4,188,319.54
32	09/01/2019	111,340.28	17,451.33	93,888.95	4,094,430.59
33	10/01/2019	111,340.28	17,060.13	94,280.15	4,000,150.44
34	11/01/2019	111,340.28	16,667.29	94,672.99	3,905,477.45
35	12/01/2019	111,340.28	16,272.82	95,067.46	3,810,409.99
2019 Totals		1,336,083.36	220,952.18	1,115,131.18	
36	01/01/2020	111,340.28	15,876.71	95,463.57	3,714,946.42
37	02/01/2020	111,340.28	15,478.94	95,861.34	3,619,085.08
38	03/01/2020	111,340.28	15,079.52	96,260.76	3,522,824.32
39	04/01/2020	111,340.28	14,678.43	96,661.85	3,426,162.47
40	05/01/2020	111,340.28	14,275.68	97,064.60	3,329,097.87
41	06/01/2020	111,340.28	13,871.24	97,469.04	3,231,628.83
42	07/01/2020	111,340.28	13,465.12	97,875.16	3,133,753.67
43	08/01/2020	111,340.28	13,057.31	98,282.97	3,035,470.70
44	09/01/2020	111,340.28	12,647.79	98,692.49	2,936,778.21
45	10/01/2020	111,340.28	12,236.58	99,103.70	2,837,674.51
46	11/01/2020	111,340.28	11,823.64	99,516.64	2,738,157.87
47	12/01/2020	111,340.28	11,408.99	99,931.29	2,638,226.58
2020 Totals		1,336,083.36	163,899.95	1,172,183.41	
48	01/01/2021	111,340.28	10,992.61	100,347.67	2,537,878.91
49	02/01/2021	111,340.28	10,574.50	100,765.78	2,437,113.13
50	03/01/2021	111,340.28	10,154.64	101,185.64	2,335,927.49
51	04/01/2021	111,340.28	9,733.03	101,607.25	2,234,320.24
52	05/01/2021	111,340.28	9,309.67	102,030.61	2,132,289.63
53	06/01/2021	111,340.28	8,884.54	102,455.74	2,029,833.89
54	07/01/2021	111,340.28	8,457.64	102,882.64	1,926,951.25
55	08/01/2021	111,340.28	8,028.96	103,311.32	1,823,639.93
56	09/01/2021	111,340.28	7,598.50	103,741.78	1,719,898.15
57	10/01/2021	111,340.28	7,166.24	104,174.04	1,615,724.11
58	11/01/2021	111,340.28	6,732.18	104,608.10	1,511,116.01
59	12/01/2021	111,340.28	6,296.32	105,043.96	1,406,072.05
2021 Totals		1,336,083.36	103,928.83	1,232,154.53	
60	01/01/2022	111,340.28	5,858.63	105,481.65	1,300,590.40
61	02/01/2022	111,340.28	5,419.13	105,921.15	1,194,669.25
62	03/01/2022	111,340.28	4,977.79	106,362.49	1,088,306.76
63	04/01/2022	111,340.28	4,534.61	106,805.67	981,501.09
64	05/01/2022	111,340.28	4,089.59	107,250.69	874,250.40
65	06/01/2022	111,340.28	3,642.71	107,697.57	766,552.83
66	07/01/2022	111,340.28	3,193.97	108,146.31	658,406.52
67	08/01/2022	111,340.28	2,743.36	108,596.92	549,809.60
68	09/01/2022	111,340.28	2,290.87	109,049.41	440,760.19
69	10/01/2022	111,340.28	1,836.50	109,503.78	331,256.41
70	11/01/2022	111,340.28	1,380.24	109,960.04	221,296.37
71	12/01/2022	111,340.28	922.07	110,418.21	110,878.16
2022 Totals		1,336,083.36	40,889.47	1,295,193.89	

2063-Chattanooga GI-$5.9 million-AMSURG-ESTIMATE

	Date	Payment	Interest	Principal	Balance
72	01/01/2023	111,340.28	462.12	110,878.16	0.00
2023 Totals		111,340.28	462.12	110,878.16	
Grand Totals		6,975,416.76	1,075,416.76	5,900,000.00	

Last interest amount increased by 0.13 due to rounding.

C, Economic Feasibility--10
Financial Statements

2063-001 Chattanooga GI

Statement of Earnings
For the Period Ending December 31, 2014

	Monthly Actual	Monthly Budget	Prior Month	YTD Actual	YTD Budget	YTD Prior Year
Gross charges:						
GI revenue	385,193	430,872	238,382	3,958,564	4,648,446	4,295,940
Total gross charges	385,193	430,872	238,382	3,958,564	4,648,446	4,295,940
Estimated reserves:						
Contractual adjustments	268,094	304,987	165,914	2,782,249	3,289,238	3,067,435
Bad debt expense	5,393	7,325	3,337	43,420	79,025	70,143
Total estimated adjustments	273,487	312,312	169,251	2,825,669	3,368,263	3,137,578
Net revenue	111,706	118,560	69,131	1,132,894	1,280,183	1,158,362
Operating expenses:						
Salaries and benefits	43,158	39,827	27,194	441,393	458,606	418,391
Medical supplies and drugs	15,134	10,873	12,189	118,714	117,307	111,586
Other variable expenses	24,765	18,061	19,604	247,873	218,373	199,088
Fixed expenses	8,623	8,537	8,496	103,019	101,524	93,081
Operating taxes	874	694	503	9,512	8,328	8,384
Depreciation	3,423	3,421	3,469	38,412	40,304	75,548
Total operating expenses	95,978	81,413	71,456	958,923	944,442	906,077
Operating income	15,728	37,147	(2,325)	173,971	335,741	252,285
Other income and (expense):						
Interest expense, net	(266)	(257)	(270)	(3,085)	(3,505)	(1,520)
Gain (loss) on sale of assets	0	0	0	(2,071)	0	0
Fees and other	90	89	31	1,273	1,068	1,982
Earnings before income taxes	15,552	36,979	(2,565)	170,088	333,304	252,747
Income tax expense	1,011	2,402	(167)	11,056	21,651	16,429
Net earnings	14,541	34,577	(2,398)	159,032	311,653	236,318

2063 Chattanooga GI

Balance Sheets
December 31, 2014

	Dec 2014	Nov 2014	Increase (Decrease)	Dec 2013	Increase (Decrease)
ASSETS					
Current assets:					
Cash and cash equivalents	28,556	15,080	13,476	13,305	15,251
Accounts receivable:					
Accounts receivable gross	367,508	330,552	36,956	400,028	(32,519)
Contractual allowance	(182,753)	(165,280)	(17,473)	(223,201)	40,448
Bad debt allowance	(52,526)	(48,060)	(4,467)	(39,610)	(12,917)
Accounts receivable, net	132,229	117,213	15,016	137,217	(4,987)
Other receivables	2,266	2,176	90	283	1,983
Supplies inventory	35,358	12,215	23,143	12,760	22,598
Prepaid and other current assets	18,329	24,041	(5,713)	20,463	(2,134)
Total current assets	216,737	170,725	46,012	184,026	32,711
Property and equipment:					
Building improvements	540,038	540,038	0	540,038	0
Equipment	1,346,824	776,582	570,243	714,095	632,729
Construction in progress	6,037	37	6,000	0	6,037
	1,892,899	1,316,657	576,243	1,254,133	638,766
Accumulated depreciation	(1,168,714)	(1,165,317)	(3,397)	(1,132,541)	(36,174)
Property and equipment, net	724,185	151,340	572,846	121,593	602,592
Intangible assets:					
Goodwill, net	2,786,643	2,786,643	0	2,786,643	0
Other intangibles	809	835	(26)	407	403
Intangible assets, net	2,787,452	2,787,478	(26)	2,787,050	403
Total assets	3,728,375	3,109,543	618,832	3,092,669	635,706
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	615,027	21,592	593,435	7,237	607,790
Current income taxes payable	40,256	42,255	(1,999)	40,357	(101)
Accrued salaries and benefits	21,850	17,963	3,887	14,118	7,732
Other accrued liabilities	0	656	(656)	0	0
Intercompany payable (receivable)	23,608	10,640	12,968	13,158	10,451
	700,741	93,106	607,635	74,870	625,871
Long-term debt	79,264	82,878	(3,614)	72,888	6,376
Other long-term liabilities	5,324	5,055	269	798	4,526
Equity:					
GP capital account	1,500,953	1,493,537	7,416	1,501,498	(545)
LP capital account	1,442,092	1,434,967	7,125	1,442,616	(523)
Total equity	2,943,046	2,928,504	14,541	2,944,114	(1,068)
Total liabilities and equity	3,728,375	3,109,543	618,832	3,092,669	635,706

AMSURG

ANNUAL REPORT 2014

Ambulatory Services Operations

The following table presents the number of procedures performed at our continuing centers and changes in the number of ASCs in operation, under development and under letter of intent for the years ended December 31, 2014, 2013 and 2012. An ASC is deemed to be under development when a LP or LLC has been formed with the physician partners to develop the ASC.

	2014	2013	2012
Procedures	1,645,350	1,609,761	1,478,888
Centers in operation, end of period (consolidated)	237	233	229
Centers in operation, end of period (unconsolidated)	9	3	2
Average number of continuing centers in operation, during period	233	230	216
New centers added, during period	10	6	18
Centers discontinued, during period	6	3	4
Centers under development, end of period	2	—	—
Centers under letter of intent, end of period	5	5	2

Of the continuing centers in operation at December 31, 2014, 150 centers performed gastrointestinal endoscopy procedures, 51 centers performed procedures in multiple specialties, 37 centers performed ophthalmology procedures and 8 centers performed orthopaedic procedures.

A significant measurement of how much our ambulatory services revenues grow from year to year for existing centers is our ambulatory services same-center revenue percentage. We define our same-center group each year as those centers that contain full year-to-date operations in both comparable reporting periods, including the expansion of the number of operating centers associated with a LP or LLC. Ambulatory services revenues at our 2014 same-center group, comprising 224 centers and constituting approximately 91% of our total number of consolidated centers, increased by 0.7% during the year ended December 31, 2014 compared to the prior period.

The following table presents selected statement of earnings data expressed in dollars (in thousands) and as a percentage of net revenue for our ambulatory services segment.

	For the Year Ended December 31,					
	2014		2013		2012	
Net revenue	$ 1,109,935	100.0%	$ 1,057,196	100.0%	$ 899,245	100.0%
Operating expenses:						
Salaries and benefits	341,906	30.8	327,585	31.0	284,528	31.6
Supply cost	163,004	14.7	153,126	14.5	126,919	14.1
Other operating expenses	230,307	20.7	216,501	20.5	185,866	20.7
Transaction costs	29,004	2.6	300	—	700	0.1
Depreciation and amortization	34,667	3.1	32,400	3.1	29,255	3.3
Total operating expenses	798,888	72.0	729,912	69.0	627,268	69.8
Gain on deconsolidation	3,411	0.3	2,237	0.2	—	—
Equity in earnings of unconsolidated affiliates	3,199	0.3	3,151	0.3	1,564	0.2
Operating income	$ 317,657	28.6%	$ 332,672	31.5%	$ 273,541	30.4%

AmSurg Corp.
Consolidated Balance Sheets
(In thousands)

	December 31, 2014	December 31, 2013
Assets		
Current assets:		
Cash and cash equivalents	$ 208,079	$ 50,840
Restricted cash and marketable securities	10,219	—
Accounts receivable, net of allowance of $113,357 and $27,862, respectively	233,053	105,072
Supplies inventory	19,974	18,414
Prepaid and other current assets	115,362	36,699
Total current assets	586,687	211,025
Property and equipment, net	180,448	163,690
Investments in unconsolidated affiliates	75,475	15,526
Goodwill	3,381,149	1,758,970
Intangible assets, net	1,273,879	27,867
Other assets	25,886	866
Total assets	$ 5,523,524	$ 2,177,944
Liabilities and Equity		
Current liabilities:		
Current portion of long-term debt	$ 18,826	$ 20,844
Accounts payable	29,585	27,501
Accrued salaries and benefits	140,044	32,294
Accrued interest	29,644	1,885
Other accrued liabilities	67,986	7,346
Total current liabilities	286,085	89,870
Long-term debt	2,232,186	583,298
Deferred income taxes	633,480	176,020
Other long-term liabilities	89,443	25,503
Commitments and contingencies		
Noncontrolling interests – redeemable	184,099	177,697
Equity:		
Mandatory convertible preferred stock, no par value, 5,000 shares authorized, 1,725 and 0 shares issued and outstanding, respectively	166,632	—
Common stock, no par value, 70,000 shares authorized, 48,113 and 32,353 shares outstanding, respectively	885,393	185,873
Retained earnings	627,522	578,324
Total AmSurg Corp. equity	1,679,547	764,197
Noncontrolling interests – non-redeemable	418,684	361,359
Total equity	2,098,231	1,125,556
Total liabilities and equity	$ 5,523,524	$ 2,177,944

See accompanying notes to the consolidated financial statements.

Financial Statements and Supplementary Data - (continued)

AmSurg Corp.
Consolidated Statements of Earnings
(In thousands, except earnings per share)

	Year Ended December 31,		
	2014	2013	2012
Revenues	$ 1,738,950	$ 1,057,196	$ 899,245
Provision for uncollectibles	(117,001)	—	—
Net revenues	1,621,949	1,057,196	899,245
Operating expenses:			
Salaries and benefits	694,576	327,585	284,528
Supply cost	164,296	153,126	126,919
Other operating expenses	284,928	216,501	185,866
Transaction costs	33,890	300	700
Depreciation and amortization	60,344	32,400	29,255
Total operating expenses	1,238,034	729,912	627,268
Gain on deconsolidation	3,411	2,237	—
Equity in earnings of unconsolidated affiliates	7,038	3,151	1,564
Operating income	394,364	332,672	273,541
Interest expense, net	83,285	29,525	16,950
Debt extinguishment costs	16,887	—	—
Earnings from continuing operations before income taxes	294,192	303,147	256,591
Income tax expense	48,103	48,654	40,893
Net earnings from continuing operations	246,089	254,493	215,698
Net earnings (loss) from discontinued operations	(1,296)	7,051	7,945
Net earnings	244,793	261,544	223,643
Less net earnings attributable to noncontrolling interests	191,092	188,841	161,080
Net earnings attributable to AmSurg Corp. shareholders	53,701	72,703	62,563
Preferred stock dividends	(4,503)	—	—
Net earnings attributable to AmSurg Corp. common shareholders	$ 49,198	$ 72,703	$ 62,563
Amounts attributable to AmSurg Corp. common shareholders:			
Earnings from continuing operations, net of income tax	$ 50,777	$ 71,009	$ 60,037
Earnings (loss) from discontinued operations, net of income tax	(1,579)	1,694	2,526
Net earnings attributable to AmSurg Corp. common shareholders	$ 49,198	$ 72,703	$ 62,563
Basic earnings per share attributable to AmSurg Corp. common shareholders:			
Net earnings from continuing operations	$ 1.29	$ 2.27	$ 1.95
Net earnings (loss) from discontinued operations	(0.04)	0.05	0.08
Net earnings	$ 1.25	$ 2.32	$ 2.03
Diluted earnings per share attributable to AmSurg Corp. common shareholders:			
Net earnings from continuing operations	$ 1.28	$ 2.22	$ 1.90
Net earnings (loss) from discontinued operations	(0.04)	0.05	0.08
Net earnings	$ 1.24	$ 2.28	$ 1.98
Weighted average number of shares and share equivalents outstanding:			
Basic	39,311	31,338	30,773
Diluted	39,625	31,954	31,608

See accompanying notes to the consolidated financial statements.

Financial Statements and Supplementary Data - (continued)

AmSurg Corp.
Consolidated Statements of Changes in Equity
(In thousands)

	AmSurg Corp. Shareholders							Noncontrolling Interests – Redeemable (Temporary Equity)
	Common Stock		Mandatory Convertible Preferred Stock		Retained Earnings	Noncontrolling Interests – Non-Redeemable	Total Equity (Permanent)	
	Shares	Amount	Shares	Amount				
Balance at January 1, 2012	31,284	$ 173,187	—	$ —	$ 443,058	$ 132,222	$ 748,467	$ 170,636
Net earnings	—	—	—	—	62,563	26,303	88,866	134,777
Issuance of restricted stock	281	—	—	—	—	—	—	—
Cancellation of restricted stock	(2)	—	—	—	—	—	—	—
Stock options exercised	842	18,214	—	—	—	—	18,214	—
Stock repurchased	(464)	(13,101)	—	—	—	—	(13,101)	—
Share-based compensation	—	6,692	—	—	—	—	6,692	—
Tax benefit related to exercise of stock	—	1,834	—	—	—	—	1,834	—
Distributions to noncontrolling interests, net of capital contributions	—	—	—	—	—	(26,514)	(26,514)	(136,356)
Acquisitions and other transactions impacting noncontrolling interests	—	252	—	—	—	174,615	174,867	6,957
Disposals and other transactions impacting noncontrolling interests	—	(3,211)	—	—	—	4,352	1,141	(632)
Balance at December 31, 2012	31,941	$ 183,867	—	$ —	$ 505,621	$ 310,978	$ 1,000,466	$ 175,382
Net earnings	—	—	—	—	72,703	49,789	122,492	139,052
Issuance of restricted stock	292	—	—	—	—	—	—	—
Cancellation of restricted stock	(16)	—	—	—	—	—	—	—
Stock options exercised	1,393	33,349	—	—	—	—	33,349	—
Stock repurchased	(1,257)	(45,964)	—	—	—	—	(45,964)	—
Share-based compensation	—	8,321	—	—	—	—	8,321	—
Tax benefit related to exercise of stock	—	7,247	—	—	—	—	7,247	—
Distributions to noncontrolling interests, net of capital contributions	—	—	—	—	—	(49,533)	(49,533)	(134,298)
Acquisitions and other transactions impacting noncontrolling interests	—	679	—	—	—	48,115	48,794	(319)
Disposals and other transactions impacting noncontrolling interests	—	(1,626)	—	—	—	2,010	384	(2,120)
Balance at December 31, 2013	32,353	$ 185,873	—	$ —	$ 578,324	$ 361,359	$ 1,125,556	$ 177,697
Net earnings	—	—	—	—	53,701	56,048	109,749	135,044
Issuance of stock	15,490	693,289	1,725	166,632	—	—	859,921	—
Issuance of restricted stock	272	—	—	—	—	—	—	—
Cancellation of restricted stock	(12)	—	—	—	—	—	—	—
Stock options exercised	111	2,630	—	—	—	—	2,630	—
Stock repurchased	(101)	(4,615)	—	—	—	—	(4,615)	—
Share-based compensation	—	10,104	—	—	—	—	10,104	—
Tax benefit related to exercise of stock	—	3,177	—	—	—	—	3,177	—
Dividends paid on preferred stock	—	—	—	—	(4,503)	—	(4,503)	—
Distributions to noncontrolling interests, net of capital contributions	—	—	—	—	—	(56,439)	(56,439)	(133,594)
Acquisitions and other transactions impacting noncontrolling interests	—	744	—	—	—	54,725	55,469	6,482
Disposals and other transactions impacting noncontrolling interests	—	(5,809)	—	—	—	2,991	(2,818)	(1,530)
Balance at December 31, 2014	48,113	$ 885,393	1,725	$ 166,632	$ 627,522	$ 418,684	$ 2,098,231	$ 184,099

See accompanying notes to the consolidated financial statements.

C, Orderly Development--7(C)
Licensing & Accreditation Inspections

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44C0001076	A. BUILDING _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGESTIVE DISORDERS ENDOSCOPY	2341 MCCALLIE AVE, SUITE 303 CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 241	416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. This STANDARD is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to follow infection control techniques during glucose monitoring for one patient (#21) of one patient observed. The findings included: Observation on May 28, 2014, at 12:00 p.m., at the nurses' station, revealed Registered Nurse (RN) #1 obtained a glucometer (device used to monitor blood sugar) from a drawer at the nurses' station, entered patient #21's room, stuck the patient's finger with a lancet (a pricking needle), obtained a drop of blood from patient #21's finger, placed the blood on a glucose strip, inserted the glucose strip in the glucometer, and after obtaining the blood sugar result RN #1 exited patient #21's room, and without cleaning the glucometer RN #1 placed the glucometer back in the drawer at the nurses' station. Review of facility policy, Blood Glucose Monitors Competency in Use-Quality Control-Cleaning, last reviewed on August 10, 2012, revealed "...cleaning with the appropriate disinfectant is performed following each use..."	Q 241	416.51 (a) SANITARY ENVIRONMENT PLAN OF CORRECTION; The Center will provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. SYSTEMIC CHANGES: All staff have been advised cleaning of the patient care equipment including the glucometer shall be based on following manufacturer's and FDA recommendations. Patient care equipment cleaning processes were reviewed with staff. (Attachment A) MONITORING AND RESPONSIBILITY: The Center Director is responsible for adherence to the Infection Control Program including cleaning of patient care equipment and the prevention of cross contamination. Monitoring of the cleaning of patient care equipment will be based on observation, interviews with staff, and surveillance of cleaning practice. Each variance will be addressed with the individual at the time of occurrence and tracked in a blinded report for trending. Trended behavior will be addressed individually for causes. If needed, additional training will occur. Results of cleaning the glucometer monitoring will be reported to the QAPI Committee with results and recommendations submitted to the Governing Body for review and reporting.	6/16/2014
	Interview with RN #1 on May 28, 2014, at 12:08 p.m., at the nurses' station, confirmed RN #1 did not clean the glucometer after use and the facility policy was not followed.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristi Ballard RN | TITLE: administrator/Center leader | (X6) DATE: 6-17-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44C0001076	A. BUILDING _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGESTIVE DISORDERS ENDOSCOPY	2341 MCCALLIE AVE, SUITE 303 CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53598	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGESTIVE DISORDERS ENDOSCOPY	2341 MCCALLIE AVE, SUITE 303 CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 607	1200-8-10-.06 (1)(g) Basic Services (1) Surgical Services. (g) Qualified registered nurses may perform circulating duties in the operating room. In accordance with applicable State laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide an operating room circulator (circulating nurse) in two of two procedure rooms. The findings included: Observations on May 27-29, 2014, revealed the surgery center had two procedure rooms in use for Endoscopy (examination of gastrointestinal tract) procedures. Continued observation revealed facility staff present in each of the procedure rooms included a Physician, a Certified Registered Nurse Anesthetist (CRNA), and an Endoscopy Technician, who was assisting the Physician with the procedure. Further observation revealed the Surgical Technicians were not directly supervised by a Registered Nurse. Interview on May 29, 2014, at 11:30 a.m., in the conference room, with the facility Administrator, revealed "...I am the back up if there are any issues, they can call me...also can use the pre-op or post-op nurse...can call any of us..." Continued interview confirmed the Endoscopy Technicians were not directly supervised by a Registered Nurse and there was not a circulating nurse in the	A 607	1200-8-10-06 (1)(g) BASIC SERVICES Qualified registered nurses may perform circulating duties in the operating room. In accordance with applicable State laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies. PLAN OF CORRECTION: Care provided to each patient at the Center will be appropriate based on patient assessment, State and federal regulations, and ASGE (American Society of Gastrointestinal Endoscopy) organization guidelines. The staffing patterns are based on the needs of the Center. The Center will develop a staffing ratio that provides the skill level necessary to promote optimum patient outcomes and efficient patient flow. The staffing plan will integrate the registered nurse in the supervisory role who will be immediately available and accommodate for skill diversity in the assistive role. The organization will provide additional RN resources when necessary. SYSTEMIC CHANGES: All staffing rules and guidelines for endoscopy have been reviewed by the Center Director and the leadership team. Constant adherence will be an ongoing expectation. The Center will recruit and train additional registered nurses to function in the supervisory role. RESPONSIBLE PARTY AND MONITORING: The Center Director will review all assignments daily for compliance. Issues of noncompliance will be reviewed with all parties involved. If 100% of the reviews demonstrate compliance, the review will become random. The results of these reviews will be tabulated and presented to the QAPI committee on a quarterly basis for review and recommendations. Recommendations will be presented to the Governing Body quarterly for review and approval.	6/20/2014

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natalie Ballard RN TITLE: Center Leader/Administrator (X6) DATE: 6-19-14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44C0001076	A. BUILDING 01 - 1 B. WING _____	05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGESTIVE DISORDERS ENDOSCOPY	2341 MCCALLIE AVE, SUITE 303 CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations and record review on 5/28/14, it was determined the facility failed to comply with the applicable codes. The findings included: 1. Records review on 5/29/14 at 11:00 AM revealed the facility failed to conduct the five year sprinkler guage inspection/ re-calibration/ replacement. The last time it was conducted was in 2006. National Fire Protection Association (NFPA) 25 Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems Table 5.1 2. Observation in the exit hallway by the offices on 5/28/14 at 11:13 AM revealed a smoke detector within three feet of an air supply. NFPA 72 National Fire Alarm Code 5.7.4.1 These findings were acknowledged by the facility during the exit conference on 5/28/14.	K 130	416.44(b)(1)LIFE SAFETY CODE STANDARD PLAN OF CORRECTION: The facility will inspect, test and maintain the automatic sprinkler system in accordance with NFPA 25. The sprinkler gauge inspection/re-calibration/ replacement will be maintained every five years. SYSTEMIC CHANGES: 1) The Center Director has contracted with a Sprinkler Inspection company who will conduct the five year inspection/re-calibration/ replacement. The inspection will be completed now and in five years. The records are now in the Center. 2) The smoke detector has been moved an additional three feet from the air supply. (Attachment B) RESPONSIBLE PARTY & MONITORING: It is the responsibility of the Center Director to ensure the facility is in compliance with the Life Safety Code Standards. The Center Director or designee will ensure that the Sprinkler System is inspected as required. The Center Director will report the results to the QAPI Committee for review and recommendation. Recommendations will be submitted to the Governing Body for review and approval.	7/13/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristi Ballard, RN
TITLE: Center Leader Administrator
(X6) DATE: 6-17-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53598	A. BUILDING: 01 - 1 B. WING _____	05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGESTIVE DISORDERS ENDOSCOPY	2341 MCCALLIE AVE, SUITE 303 CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies Based on observations, testing, and records review on 5/28/14, it was determined the facility was in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board of Licensing Health Care Facilities and Chapter 1200-08-10 Standards For Ambulatory Surgery Centers.	A 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Digestive Disorders Endoscopy Center

Staff Roster and Sign In Sheet for Staff Education/Inservices

Topic: Blood Glucose Machine **Date: June 16, 2014**

Presented By: Kristi Ballard

Staff Member Name	Title	Signature
Kristi Ballard	RN	Kristi Ballard, RN
Lori Giles	RN	
Jennifer Morrow	RN	Jennifer S. Morrow, RN
Cindy Rogers	RN	Cindy Rogers RN
Kelley Tate	RN	Kelley Tate RN
Durinda Waters	RN	Durinda Waters
Jennifer Wright	RN	

FORM - BLOOD GLUCOSE MONITORS Competency Checklist

Digestive Disorders Endoscopy Center

Critical Behavior	N/A	1	2	3	4	Date	Initial
Demonstrates knowledgeable use of monitor				X		6-16-14	CR/KB
Verifies monitor lot number and number on test strips vial are the same				X		6-16-14	CR/KB
Checks system with check strip				X		6-16-14	CR/KB
Checks system with control solution				X		6-16-14	CR/KB
Obtains blood sample using manual lancet				X		6-16-14	CR/KB
Test blood sample				X		6-16-14	CR/KB
Care of the monitor				X		6-16-14	CR/KB

Scoring:
N/A – not applicable
1-unsatisfactory
2 – below normal
3 – normal/expected

Kristi Ballard
Employee Name

Cindy Rogers
Verified by

Last Reviewed: 8/10/2012

FORM - BLOOD GLUCOSE MONITORS Competency Checklist

Digestive Disorders Endoscopy Center

Critical Behavior	N/A	1	2	3	4	Date	Initial
Demonstrates knowledgeable use of monitor				X		6-16-14	KB
Verifies monitor lot number and number on test strips vial are the same				X		6-16-14	KB
Checks system with check strip				X		6-16-14	KB
Checks system with control solution				X		6-16-14	KB
Obtains blood sample using manual lancet				X		6-16-14	KB
Test blood sample				X		6-16-14	KB
Care of the monitor				X		6-16-14	KB

Scoring:
N/A – not applicable
1-unsatisfactory
2 – below normal
3 – normal/expected

Lori Giles
Employee Name

Kristi Ballard
Verified by

Last Reviewed: 8/10/2012

FORM - BLOOD GLUCOSE MONITORS Competency Checklist

Digestive Disorders Endoscopy Center

Critical Behavior	N/A	1	2	3	4	Date	Initial
Demonstrates knowledgeable use of monitor				X		6-16-14	KB
Verifies monitor lot number and number on test strips vial are the same				X		6-16-14	KB
Checks system with check strip				X		6-16-14	KB
Checks system with control solution				X		6-16-14	KB
Obtains blood sample using manual lancet				X		6-16-14	KB
Test blood sample				X		6-16-14	KB
Care of the monitor				X		6-16-14	KB

Scoring:
N/A – not applicable
1-unsatisfactory
2 – below normal
3 – normal/expected

Jennifer Morrow
Employee Name

K Ballard, RN
Verified by

Last Reviewed: 8/10/2012

FORM - BLOOD GLUCOSE MONITORS Competency Checklist

Digestive Disorders Endoscopy Center

Critical Behavior	N/A	1	2	3	4	Date	Initial
Demonstrates knowledgeable use of monitor				X		6-16-14	KT KB
Verifies monitor lot number and number on test strips vial are the same				X		6-16-14	KT KB
Checks system with check strip				X		6-16-14	KT KB
Checks system with control solution				X		6-16-14	KT KB
Obtains blood sample using manual lancet				X		6-16-14	KT KB
Test blood sample				X		6-16-14	KT KB
Care of the monitor				X		6-16-14	KB KT

Scoring:
N/A – not applicable
1-unsatisfactory
2 – below normal
3 – normal/expected

Kelley Tate KelleyTate
Employee Name

Kristi Ballard, RN
Verified by

Last Reviewed: 8/10/2012

FORM - BLOOD GLUCOSE MONITORS Competency Checklist

Digestive Disorders Endoscopy Center

Critical Behavior	N/A	1	2	3	4	Date	Initial
Demonstrates knowledgeable use of monitor				X		6-16-14	CR/KB
Verifies monitor lot number and number on test strips vial are the same				X		6-16-14	CR/KB
Checks system with check strip				X		6-16-14	CR/KB
Checks system with control solution				X		6-16-14	CR/KB
Obtains blood sample using manual lancet				X		6-16-14	CR/KB
Test blood sample				X		6-16-14	CR/KB
Care of the monitor				X		6-16-14	CR/KB

Scoring:
N/A – not applicable
1-unsatisfactory
2 – below normal
3 – normal/expected

Cindy Rogers
Employee Name

Kristi Ballard
Verified by

Last Reviewed: 8/10/2012

FORM - BLOOD GLUCOSE MONITORS Competency Checklist

Digestive Disorders Endoscopy Center

Critical Behavior	N/A	1	2	3	4	Date	Initial
Demonstrates knowledgeable use of monitor				X			JW/KB
Verifies monitor lot number and number on test strips vial are the same				X			JW/KB
Checks system with check strip				X			JW/KB
Checks system with control solution				X			JW/KB
Obtains blood sample using manual lancet				X			JW/KB
Test blood sample				X			JW/KB
Care of the monitor				X			JW/KB

Scoring:
N/A – not applicable
1-unsatisfactory
2 – below normal
3 – normal/expected

Jennifer Wright
Employee Name

Kristi Ballard
Verified by

Last Reviewed: 8/10/2012

FORM - BLOOD GLUCOSE MONITORS Competency Checklist

Digestive Disorders Endoscopy Center

Critical Behavior	N/A	1	2	3	4	Date	Initial
Demonstrates knowledgeable use of monitor				X		6-16-14	DW/KB
Verifies monitor lot number and number on test strips vial are the same				X		6-16-14	DW/KB
Checks system with check strip				X		6-16-14	DW/KB
Checks system with control solution				X		6-16-14	DW/KB
Obtains blood sample using manual lancet				X		6-16-14	DW/KB
Test blood sample				X		6-16-14	DW/KB
Care of the monitor				X		6-16-14	DW/KB

Scoring:
N/A – not applicable
1-unsatisfactory
2 – below normal
3 – normal/expected

Durinda Waters, RN
Employee Name

Kristi Ballard, RN
Verified by

Last Reviewed: 8/10/2012

Policy Title:	BLOOD GLUCOSE MONITORS Competency in Use-Quality Control-Cleaning		
Approved:	8/10/2012	Page:	1 of 2
Effective:	9/10/2012	Retired:	

POLICY:

A blood glucose monitor is properly used to evaluate patients' blood glucose levels.
All persons responsible for use of blood glucose monitors in the evaluation of patient blood glucose levels are proficient in the monitor's use.
The blood glucose monitor is properly cleaned and maintained according to manufacturer guidelines.

PURPOSE:

To ensure accurate results of blood glucose monitoring
To ensure staff competency in use of blood glucose monitors
To ensure accurate blood glucose assessment by proper care of equipment

PROCEDURE:

Blood glucose levels are obtained as ordered using a blood glucose monitor with the results appropriately documented.

Competency

All RNs providing direct patient care are proficient in the use of the peripheral blood glucose monitor. All RNs as well as those newly hired, receive orientation /inservice on the blood glucose monitor and perform return demonstrations before being allowed to use the blood glucose monitor unsupervised.

Proficiency is evaluated based on the manufacturer's guidelines for the specific monitor.

Competency testing is performed annually.

Learning Resources include:
Blood Glucose Monitor, Use of
Manufacturer Instruction Manual

Quality Control and Cleaning

Blood glucose monitors are professional grade quality for accuracy of testing.
The quality control testing procedures as outlined in the manufacturer's manual are followed.

Maintenance

Cleaning with the appropriate disinfectant is performed following each use. (Refer to User Manual for cleaning details)

Trouble Shooting

Refer to User Manual for error codes and trouble shooting.

Policy Title:	POINT of CARE DEVICES		
Approved:	8/10/2012	Page:	1 of 2
Effective:	9/10/2012	Retired:	

POLICY:

The Center complies with current Center for Disease Control and Prevention (CDC) and American Association of Diabetes Educators (AADE) recommendations for the prevention of transmission of blood borne infectious agents during blood glucose monitoring and other point of care testing.

PURPOSE:

To prevent the transmission of blood borne infections during point of care testing, such as blood glucose monitoring

PROCEDURE:

The following procedures apply to the use of point of care testing devices, including glucometers:

- Gloves are worn when performing finger sticks
- A disposable single-use, auto-disabling lancet is the only type of device that is used when performing finger-sticks in the Center. Blood is directed away from the face when performing a finger puncture to prevent blood splash to face or mucous membranes.
- Used lancets are disposed in an approved sharps container
- Lancets are not reused
- Used lancets are not recapped, bent or broken
- Point of care testing devices chosen for the Center are designed for use on multiple patients, as indicated by the manufacturer's indications and instructions. Instructions include directions for cleaning and disinfecting the device.
- Gloves are worn while cleaning the device thoroughly after each use and disinfecting it according to manufacturer's recommendation with an EPA approved disinfectant
- Countertops and surfaces that have been contaminated with blood or body fluids are immediately and thoroughly cleaned with an EPA approved disinfectant

- Accidental needle sticks and mucous membrane exposure are reported and managed in accordance with regulations established by the Occupational Safety and Health Administration (OSHA) and recommendations promulgated by the CDC.

Hand Hygiene and Gloves during Point of Care Testing

- Gloves are worn during finger stick glucose monitoring and during any other procedure that involves potential exposure to blood or body fluids
- Gloves are changed between patient contacts
- Gloves are changed when there is contact with a potentially blood-contaminated object or finger stick wounds before touching clean surfaces
- Gloves are removed and discarded in appropriate receptacles after every procedure that involves potential exposure to blood or body fluids, including finger stick blood sampling
- Hand hygiene (i.e., hand washing with soap and water or use of an alcohol-based hand rub) is performed immediately after removal of gloves and before touching other medical supplies intended for use on other patients
- Hands are washed immediately with soap and water if they become contaminated with blood or body fluids

REFERENCE:

"Infection Prevention during Blood Glucose Monitoring and Insulin Administration"
http://www.cdc.gov/injectionsafety/blood-glucose-monitoirng.html

Disinfection and Sterilization in Healthcare Facilities
http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection_Nov_2008

AADE Position Statement and Guidelines
http://www.diabeteseducator.org/export/sites/aade/_resources/pdf/EducProvidersBloodborneInfections.pdf

Report of Inspection

5 Year Internal Check Valve and Pipe

Date

Century Pipe Protection
2625-F Pinemeadow Cou
Duluth, GA 30096
Office: 770-506-238
Fax: 770-506-287

Inspection Site

Property Name Parkridge
Address 2333 McCallie
City Chatta State TN Zip

Customer

Sample Customer
Address
City State Zip

System ID:
Conducted by:
Inspection reference:

Signatures

Inspector / Lic #	Inspector - Signature	Date: 6-9-14 Time:	I state the information on this form is correct at the ti place of my inspection, and that all equipment testec time was left in operational condition upon completio inspection except as noted.
Franklin Curtis	FrD Curtis		

System Information

Location of Main: At Riser / End of Main **Location of Branch Line:** End of main

Location of Check Valve: At Riser **Check Valve size:** 6" **Type:** Viking H-2

	Yes	N/A	No
Was system in service before conducting Inspection?	✓		
Were pertinent parties notified before conducting inspection?	✓		
Adequate drainage ensured before draining system?	✓		
Was alternative nondestructive examination method used?		✓	
No foreign materials indicated by examination method?			✓
Interior of pipe checked for organic or inorganic material?	✓		
No significant foreign material obderved?			✓
No tubercles or slime observed?			
Flushing program implemented where material was observed?	✓	✓	

Condition

Condition of main pipe inspected, Good, minor rust

Condition of branch line pipe inspected, Good, no blockage

Condition of Check Valve inspected, Good

Internal Images

Images of Main:

Images of Branchlines:

Images of check valve:

Recommendations

Century
Fire Protection
Inspection & Service Division

2625-F Pinemeadow Court
Duluth, Ga 30096
Ph 770-506-2388 Fax 770-506-2878

FDC/Standpipe 5yr Hydro Test

Building Name Parkridge Medical Center / Plaza 3

Building Address 2333 McCallie Ave, Chattanooga, TN

Inspector Franklin Curtis

Location of FDC West side of building / Riser Room

Pressure hold time 2 hrs

PSI hold at 204 PSI

Recommendations N/A

Witness 6-10-14

Signature Date 6-10-14

tyco / Fire & Security / SimplexGrinnell

FIRE PROTECTION SYSTEMS COMPANY
3200 North Hawthorne Street
Chattanooga, Tn. 37406
PH. (423) 698-4418 Fax (423) 698-5979

Inspection report No. ____
Conferred With: ____

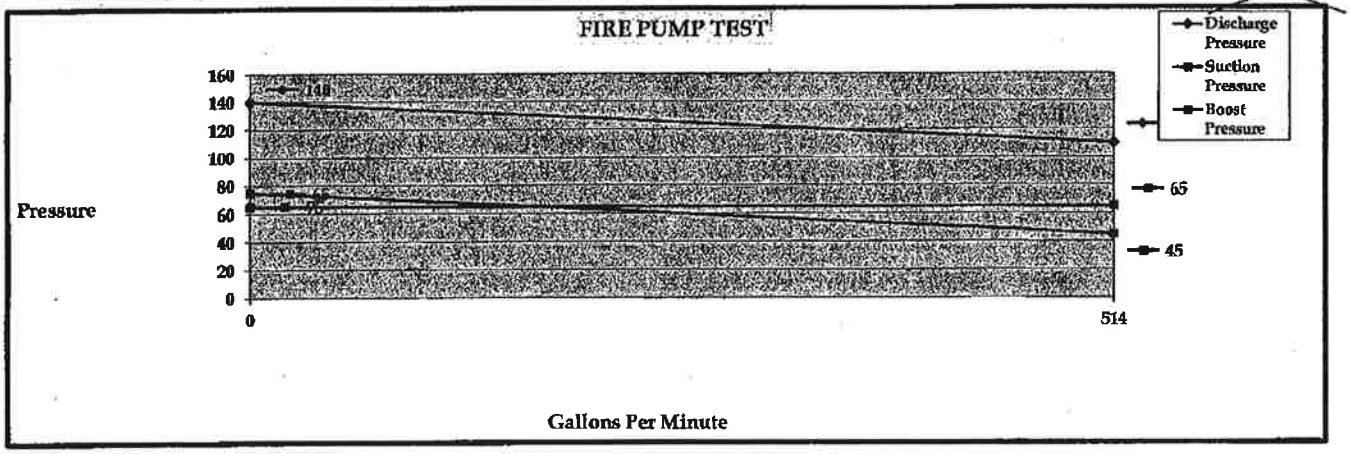
FIRE PUMP PERFORMANCE TEST

Report To: CASSIDY/TURLEY
Street: 2337 McCALLIE
City: CHATT State: TN Zip: 37404
Attn: STEVE
Phone: 423-493-1244 Fax:

Location Inspected: PARKRIDGE PLAZA 3
Inspector's Name: Jamie Meeks & Nathan Sartain
Inspection Date: 6/5/14
TASK #: 28690888
Page 1 of 2

PUMP INFORMATION	Shaft		Manufacture		Approved		Shop or Serial No.		Model Number														
	X	Horizontal	PATTERSON		X	Yes	FP-C2022		N/A														
		Vertical				No																	
	Gallons/minute		Rated Head/Ft.		Net		Rated RPM		City Supply		Size Conn.				Tank Supply		Tank Height						
	1000	GPM	100	PSI		PSI	3525	RPM	6		6	Inch			N/A	Yes	N/A	Feet					
Driver	Manufacture		Approved				Shop or Serial No.		Model Number						Horse Power		Rated RPM						
	U.S. ELECTRIC		X	Yes			691084								50	H.P.	3535	RPM					
				No			YO3Y0200455R-1																
	Electric M.		Rated Volts		Oper. Volt		Rated Amps		Amps @ 150		Phase				Cycles		Service Factor						
		Elec.		A.C.		A.C.	137	Amps	90	Amps	3	Phase			60	Hz.	1.15						
Controller	Manufacture		Approved		Start		Psi		Stop		Psi				Jockey Pump								
	FIRETROL		X	Yes																			
				No				Manual			Manual				X	Yes							
	Shop or Serial No.		Model Number				X	Pressure Drop			Auto					No							
			FTA1350-AA100H				X	Auto							175	Off							
								Waterflow							150	On							

Revolutions Per/minute		Discharge Pressure		Suction Pressure		Net Pressure		Streams No.	Size	Pitot#	GPM	%	Voltage	Amp. Reading	Steam Press. Throtl	Chest
3554	RPM	140	Psi	65	Psi	75	Psi	0	Churn	0	0	0	213-213-212	151-150-153		
3553	RPM	110	Psi	65	Psi	45	Psi	1	1 3/4	32	514	51%	213-212-213	151-153-153		
3547	RPM	75	Psi	55	Psi	20	Psi	2	1 3/4	2X32	1028	102%	212-212-211	148-149-151		
	RPM		Psi		Psi		Psi									



Additional Comments: 1 fire pump would not get 150% due to suction discharge pressure running the same and pump making noise. Shut off test

Signature of owner or owners representative ____ DATE ____

Duplicate to ____
Street ____
City ____ State ____ Zip ____
Attn: ____

tyco Fire & Security

SimplexGrinnell

DRY PIPE VALVE TRIP TEST REPORT

FOR CASSIDY/TURLEY (PARKRIDGE PLAZA 3) MONTH AND YEAR 6/2014

STREET 2333 McCALLIE AVE. CITY CHATTANOOGA STATE TN CUSTOMER NO. Task 41022092

DATE OF TRIP TEST 6/5/14 INSPECTOR Jamie Meeks

NOTE: BEFORE ANY DRY PIPE VALVE IS TRIP TESTED, THE WATER SUPPLY LINE TO IT SHOULD BE THOROUGHLY FLUSHED. THE TWO INCH DRAIN BELOW THE VALVE SHOULD BE OPENED WIDE, AND WATER AT FULL PRESSURE SHOULD BE DISCHARGED LONG ENOUGH TO CLEAR THE PIPE OF ANY ACCUMULATION OF SCALE OR FOREIGN MATERIAL. IF THERE IS A HYDRANT ON THE SUPPLY LINE, THIS HYDRANT SHOULD BE FLUSHED BEFORE THE TWO INCH DRAIN IS OPENED. THE DRIP VALVE ON THE DRY PIPE VALVE SHOULD BE CHECKED BEFORE TRIPPING THE DRY PIPE VALVE, TO SEE THAT IT IS IN OPERATING CONDITION.

DRY PIPE VALVES		SYSTEM NO.	SYSTEM NO.	SYSTEM NO.	SYSTEM NO.
VALVE SERIAL NUMBER		9234			
MANUFACTURER (NAME)		VIKING			
VALVE MODEL		E-2			
VALVE SIZE		4"			
CONTROLLING SPRINKLERS	(LOCATION)	PARKING GARAGE			
	(NUMBER)	100 (APPROX)	(APPROX)	(APPROX)	(APPROX)
DATE LAST TRIP TESTED?		6/13			
DATE LAST OPERATED?		6/13			
PRESSURE BEFORE TEST	AIR	50 LBS	LBS	LBS	LBS
	WATER	170 LBS	LBS	LBS	LBS
SIZE AND LOCATION OF TEST VALVE		½"			
WAS GATE VALVE BELOW DRY VALVE OPEN WIDE AT TEST? (IF NOT, HOW MANY TURNS?)		OPEN			
VALVE TRIPPED AT	AIR PRESSURE	25 LBS	LBS	LBS	LBS
	WATER PRESSURE	170 LBS	LBS	LBS	LBS
	TIME	MIN 24 SEC	MIN SEC	MIN SEC	MIN SEC
SYSTEM FLOODED, LIST TIME WATER REACHED TEST OPENING.		MIN 40 SEC	MIN SEC	MIN SEC	MIN SEC
PERFORMANCE		SATISFACTORY			
VALVE CONDITION	INTERIOR OF BODY	GOOD			
	MOVING PARTS	GOOD			
	RUBBER FACING	GOOD			
	SEATS	GOOD			
	RESET?	YES			
DID ALARMS OPERATE AT TRIP TEST?		YES			
ALL LOW POINT DRAINS BLOWN OUT?		YES			
WATER CONTROL VALVE LEFT OPEN AND SEALED?		YES			
ALARM CONTROL VALVE LEFT OPEN AND SEALED?		YES			

QUICK OPENING DEVICES	SYSTEM NO.	SYSTEM NO.	SYSTEM NO.	SYSTEM NO.
DEVICE SERIAL NUMBER	N/A			
MANUFACTURER (NAME)				
TYPE AND MODEL				
AIR PRESSURE IN UPPER CHAMBER	LBS	LBS	LBS	LBS
QUICK OPENING DEVICE TRIPPED AT	SEC LBS	SEC LBS	SEC LBS	SEC LBS
PERFORMANCE				
QUICK OPENING DEVICE LEFT IN SERVICE AND CONTROL OPEN AND SEALED?				

LIST ANY UNSATISFACTORY CONDITIONS:

REMARKS:

tyco Fire & Security

SimplexGrinnell

DRY PIPE VALVE TRIP TEST REPORT

FOR CASSIDY/TURLEY (PARKRIDGE PLAZA 3) MONTH AND YEAR 6/2014

STREET 2333 McCALLIE AVE. CITY CHATTANOOGA STATE TN CUSTOMER NO. Task 41022092

DATE OF TRIP TEST 6/5/14 INSPECTOR Jamie Meeks

NOTE: BEFORE ANY DRY PIPE VALVE IS TRIP TESTED, THE WATER SUPPLY LINE TO IT SHOULD BE THOROUGHLY FLUSHED. THE TWO INCH DRAIN BELOW THE VALVE SHOULD BE OPENED WIDE, AND WATER AT FULL PRESSURE SHOULD BE DISCHARGED LONG ENOUGH TO CLEAR THE PIPE OF ANY ACCUMULATION OF SCALE OR FOREIGN MATERIAL. IF THERE IS A HYDRANT ON THE SUPPLY LINE, THIS HYDRANT SHOULD BE FLUSHED BEFORE THE TWO INCH DRAIN IS OPENED. THE DRIP VALVE ON THE DRY PIPE VALVE SHOULD BE CHECKED BEFORE TRIPPING THE DRY PIPE VALVE, TO SEE THAT IT IS IN OPERATING CONDITION.

DRY PIPE VALVES		SYSTEM NO.	SYSTEM NO.	SYSTEM NO.	SYSTEM NO.
VALVE SERIAL NUMBER		9234			
MANUFACTURER (NAME)		VIKING			
VALVE MODEL		E-2			
VALVE SIZE		4"			
CONTROLLING SPRINKLERS	(LOCATION)	PARKING GARAGE			
	(NUMBER)	100 (APPROX)	(APPROX)	(APPROX)	(APPROX)
DATE LAST TRIP TESTED?		6/13			
DATE LAST OPERATED?		6/13			
PRESSURE BEFORE TEST	AIR	50 LBS	LBS	LBS	LBS
	WATER	170 LBS	LBS	LBS	LBS
SIZE AND LOCATION OF TEST VALVE		½"			
WAS GATE VALVE BELOW DRY VALVE OPEN WIDE AT TEST? (IF NOT, HOW MANY TURNS?)		OPEN			
VALVE TRIPPED AT	AIR PRESSURE	25 LBS	LBS	LBS	LBS
	WATER PRESSURE	170 LBS	LBS	LBS	LBS
	TIME	MIN 24 SEC	MIN SEC	MIN SEC	MIN SEC
IF SYSTEM FLOODED, LIST TIME WATER REACHED TEST OPENING.		MIN 40 SEC	MIN SEC	MIN SEC	MIN SEC
PERFORMANCE		SATISFACTORY			
VALVE CONDITION	INTERIOR OF BODY	GOOD			
	MOVING PARTS	GOOD			
	RUBBER FACING	GOOD			
	SEATS	GOOD			
	RESET?	YES			
DID ALARMS OPERATE AT TRIP TEST?		YES			
ALL LOW POINT DRAINS BLOWN OUT?		YES			
WATER CONTROL VALVE LEFT OPEN AND SEALED?		YES			
ALARM CONTROL VALVE LEFT OPEN AND SEALED?		YES			

QUICK OPENING DEVICES	SYSTEM NO.	SYSTEM NO.	SYSTEM NO.	SYSTEM NO.
DEVICE SERIAL NUMBER	N/A			
MANUFACTURER (NAME)				
TYPE AND MODEL				
AIR PRESSURE IN UPPER CHAMBER	LBS	LBS	LBS	LBS
QUICK OPENING DEVICE TRIPPED AT	SEC LBS	SEC LBS	SEC LBS	SEC LBS
PERFORMANCE				
QUICK OPENING DEVICE LEFT IN SERVICE AND CONTROL OPEN AND SEALED?				

LIST ANY UNSATISFACTORY CONDITIONS:

REMARKS:

SimplexGrinnell BE SAFE.

Task # 41020514
R# 28690888

REPORT OF SPRINKLER INSPECTION

Date: June 5, 2014

CUSTOMER	CASSIDY/TURLEY	INSPECTOR NAME	Jamie Meeks
BUILDING / LOCATION	PLAZA 3	SIMPLEXGRINNELL OFFICE	SimplexGrinnell
STREET	2333 McCallie Ave.		3200 North Hawthorne St.
CITY / ST/PROV / ZIP/PC	Chattanooga, TN. 37404		Chattanooga, TN 37406
ATTN:	Kita	PHONE #	423-698-4418
PHONE #	493-1244 or STEVEN 595-0280	LICENSE #	TN 159

	YES	NA	NO
1. GENERAL (To be answered by Customer.)			
a. Have there been any changes in the occupancy classification, machinery or operations since the last inspection?	☐	☐	☑
b. Have there been any changes or repairs to the fire protection systems since the last inspection?	☐	☐	☑
c. If a fire has occurred since the last inspection, have all damaged sprinkler system components been replaced?	☐	☑	☐
If answered "yes" to a, b or c, list changes in Section 13.			
d. Has the piping in all dry systems been checked for proper pitch within the past five years?	☑	☐	☐
Date last checked: JULY 2009, (check recommended at least every 5 years)			
e. Has the piping in all systems been checked for obstructive materials?	☑	☐	☐
Date last checked: Jul-09 (check required at least every 5 years)			
f. Have all fire pumps been tested to full capacity using hose streams or flow meters within the past 12 months?	☐	☑	☐
g. Are gravity, surface or pressure tanks protected from freezing?	☐	☑	☐
h. Standard sprinklers 50 years old or older? ☐ QR (20yr) ☐ Dry (10 yr) ☐ >325F/163C (5yr) ☐ Corrosive env't. (5yr.)	☐	☑	☐
(Testing or replacement required for these types of sprinklers.)			
i. Are any extra high temperature solder sprinklers regularly exposed to temperatures near 300F/149C?	☐	☑	☐
j. Have gauges been tested, calibrated or replaced in the last 5 years? Date 2009	☑	☐	☐
k. Alarm valves and associated trim been internally inspected past 5 years? Date 2009	☑	☐	☐
l. Check valves internally inspected in the last 5 years? Date 2009	☑	☐	☐
m. Has the private fire main been flow tested in last 5 years? Date MAIN DRAIN TEST TODAY	☑	☐	☐
n. Standpipe 5 year requirements.			
1. Dry standpipe hydrostatic test Date	☐	☑	☐
2. Flow test Date 11/17/2009	☑	☐	☐
3. Hose hydrostatic test Date	☐	☑	☐
4. Pressure control valve test Date	☐	☑	☐
5. Pressure reducing valve test Date	☐	☑	☐
o. Have pressure reducing valves been tested at full flow within the past 5 years? Date	☐	☑	☐
q. Have master pressure reducing valves been tested at full flow within the past 1 year?	☐	☑	☐
r. Have the sprinkler systems been extended to all areas of the building?	☐	☐	☑
s. Are the building areas protected by a wet system heated, including its blind attics and perimeter areas?	☑	☐	☐
t. Are all exterior openings protected against the entrance of cold air?	☑	☐	☐

2. CONTROL VALVES			
a. Are all sprinkler system main control valves and all other valves in the appropriate open or closed position?	☑	☐	☐
b. Are all control valves sealed or supervised in the open position?	☑	☐	☐

Control Valves	# of Valves	Type	Easily Accessible YES	Easily Accessible NO	Signs YES	Signs NO	Valve Open YES	Valve Open NO	Secured? If Yes, How? YES	Secured? If Yes, How? NO	(Sealed?) (Locked?) (Supvd.?)	Supervision Operational YES	Supervision Operational NO
CITY CONNECTION	1	PIV	☑	☐	☑	☐	☑	☐	☑	☐	Locked	☐	☑
TANK			☐	☐	☐	☐	☐	☐	☐	☐		☐	☐
PUMP			☐	☐	☐	☐	☐	☐	☐	☐		☐	☐
SECTIONAL			☐	☐	☐	☐	☐	☐	☐	☐		☐	☐
SYSTEM	5	Butterfly	☑	☐	☑	☐	☑	☐	☑	☐	Supervised	☑	☐
ALARM LINE			☐	☐	☐	☐	☐	☐	☐	☐		☐	☐

Location of Control Valves:

RY VALVE IS LOCATED IN THE FIRE PUMP ROOM	
ach Level Sprinkler Control Valve and Water Flow is in JANITOR	
CLOSETS, KEY IS NEEDED	

SimplexGrinnell BE SAFE.

REPORT OF SPRINKLER INSPECTION

3. WATER SUPPLIES

a. Water supply sources? City: ☑ Gravity Tank: ☐

Pressure Fire Pump & Tank ☐
Pressure Fire Pump & City ☑
Pressure Fire Pump & Pond ☐

Main Drain Test Results Made During This Inspection

Test Pipe Located	Size Test Pipe	Static Supply Pressure Before	Residual Pressure	Return time to Static Pressure	Test Pipe Located	Size Test Pipe	Static Supply Pressure Before	Residual Pressure	Return time to Static Pressure
MAIN DRAIN-DRY VA	2"	170	70	2sec	Lev el 3	1"	FLUSHED	no gauge	2sec
ALARM VALVE	2"	170	70	2SEC	Level 2	!"	FLUSHED	"	2sec
Level 4	1"	Flow & Tampe	Tamper	2sec	Level 1	1"	FLUSHED	"	2sec

4. TANKS, PUMPS, FIRE DEPT. CONNECTIONS

	YES	NA	NO
a. Do fire pumps, gravity, surface or pressure tanks appear to be in good external conditions?	☑		
b. Are gravity, surface and pressure tanks at the proper pressure and/or water levels?		☑	
c. Has the storage tank been internally inspected in the last 3 yrs. (unlined) or 5 yrs. (lined)? Date:		☑	
d. Are fire dept. connections in satisfactory condition, couplings free, caps or plugs in place and check valves tight?	☑		
e. Are fire dept. connections visible and accessible?	☑		

5. WET SYSTEMS

	YES	NA	NO
a. No. of systems: 4 Make & Model WET RISERS WITH FLOW DETECTORS			
b. Are cold weather valves in the appropriate open or closed position?		☑	
If closed, has piping been drained?		☑	
c. Has the Customer been advised that cold weather valves are not recommended?		☑	
d. Have all the antifreeze systems been tested? Date:		☑	

The antifreeze tests indicated protection to: (Note temp & type for each. Example: -15F/126C glycol or -15F/-26C glycerin)

System 1)		2)		3)	
4)		5)		6)	

e. Did alarm valves, water flow alarm devices and retards test satisfactorily?	☑		

6. DRY SYSTEMS

	YES	NA	NO
a. No. of systems: 1 Make & Model: VIKING C			
Date last trip tested: 6/5/2014 ☐ Partial ☑ Full			
b. Are the air pressure and priming water levels normal?	☑		
c. Did the air compressor operate satisfactorily?	☑		
d. Air compressor oil checked? ☐ Belt? ☐			
e. Were Auxiliary / Low Point drains drained during this inspection? No. of Drains: 1	☑		
Locations 1) 2)			
3) 4)			
f. Did all quick opening devices operate satisfactorily? Make: Model:		☑	
g. Did all the dry valves operate satisfactorily during this inspection?	☑		
h. Is the dry valve house heated?	☑		
i. Do dry valves appear to be protected from freezing?	☑		

7. SPECIAL SYSTEMS

	YES	NA	NO
a. No. of systems: NA Make & Model:			
Type:			
b. Were valves tested as required?			
c. Did all heat responsive systems operate satisfactorily?			
d. Did the supervisory features operate during testing?			
e. Has a supplemental test form for this system been completed and provided to the customer? (Please attach)			

Auxiliary equipment: No. Type:

Location

Test results

8. ALARMS

	YES	NA	NO
a. Did the water motors and gong operate during testing?	☑		
b. Did the electric alarms operate during testing?	☑		
c. Did the supervisory alarms operate during testing?	☑		

REPORT OF SPRINKLER INSPECTION

9. SPRINKLERS - PIPING	YES	NA	NO
a. Do sprinklers generally appear to be in good external condition?	☑	☐	☐
b. Do sprinklers generally appear to be free of corrosion, paint, or loading and visible obstructions?	☐	☐	☑
c. Are extra sprinklers and sprinkler wrench available on the premises? (#, size, finish, temp, brand, of spare heads)	☑	☐	☐
d. Does the exposed exterior condition of piping, drain valves, check valves, hangers, pressure gauges, open sprinklers and strainers appear to be satisfactory?	☑	☐	☐
e. Does the hand hose on the sprinkler system appear to be in satisfactory condition?	☐	☑	☐
f. Does there appear to be proper clearance between the top of all storage and the sprinkler deflector?	☑	☐	☐

10. EXPLANATION OF "NO" ANSWERS AND DEFICIENCIES. (Sections 1d thru 9):

ALL SPRINKLER HEADS IN PARKING GARAGE NEED TO BE REPLACED (165 STANDARD SEMI-RECESSED HEADS) DUE TO CORROSION.

ALSO COULD NOT GET 150% OUT OF FIRE PUMP WHEN PERFORMING ANNUAL TEST. SUCTION AND DISCHARGE PRESSURE WERE RUNNING AT SAME PRESSURES AND PUMP WAS NOT SOUNDING GOOD. NEED TO GET PRESURE RELIEF VALVE LOOKED AT.

11. THE INSPECTOR SUGGESTS THE FOLLOWING NECESSARY IMPROVEMENTS. THESE SUGGESTIONS ARE NOT THE RESULT OF AN ENGINEERING SURVEY AND DO NOT REFLECT CONDITIONS ABOVE CEILINGS OR IN CONCEALED SPACES:

HEAT ALL AREAS DURING COLD WEATHER

2. ADJUSTMENTS OR CORRECTIONS MADE:

ALARMS RESPONDED TO FULL FLOW TEST. SYSTEM FLUSHED AT THE MAIN DRAIN AND INSPECTOR'S TEST. ALL CONTROL VALVES OPERATED AND TAMPER DEVICES ACTIVATED. ALARMS WERE VERIFIED AT THE ALARM PANEL. ALARMS NORMAL AFTER TEST.

ALSO REPLACED A 6 INCH LONG 1 1/4" NIPPLE THAT HAD PIN HOLES IN IT COMING OFF FIRE PUMP GOING TO RELIEF VALVE.

13. LIST CHANGES IN OCCUPANCY, HAZARD OR FIRE PROTECTION SYSTEM, AS ADVISED BY CUSTOMER IN SECTION 1 a-c:

14. INSPECTION DEFICIENCIES AND SUGGESTED IMPROVEMENTS WERE DISCUSSED WITH THE CUSTOMER /CUSTOMER REPRESENTATIVE.	YES	NO
	☑	☐

If No, explain. _____

IMPORTANT NOTICE TO CUSTOMER Customer acknowledges and agrees that, in the absence of a Service Agreement between the parties, services hereunder are performed pursuant to the terms and conditions of this Report, agrees that the services have been completed to Customer's satisfaction and that the system is in good working order and repair, unless services performed were of a temporary nature, in which case Customer acknowledges that part of customer's system may have been bypassed or is otherwise inoperable until service can be completed. **CUSTOMER'S ATTENTION IS DIRECTED TO THE LIMITATION OF LIABILITY, WARRANTY, INDEMNITY AND OTHER CONDITIONS AT THE REVERSE SIDE/END OF THIS REPORT.** This Agreement has been drawn up and executed in English at the request of and with the full concurrence of Customer. Ce contract a été rédigé en anglais à la demande et avec l'assentiment du client.

CUSTOMER	Date:	
PRINT NAME		SIMPLEXGRINNELL INSPECTOR SIGNATURE

DUPLICATE TO: _____

STREET: _____

CITY, STATE AND ZIP: _____

ATTN: _____

TERMS AND CONDITIONS

1. Limitation of Liability; Limitations of Remedy. It is understood and agreed by the Customer that Company is not an insurer and that insurance coverage, if any, shall be obtained by the Customer and that amounts payable to Company hereunder are based upon the value of the services and the scope of liability set forth in this agreement and are unrelated to the value of the Customer's property and the property of others located on the premises. Customer agrees to look exclusively to the Customer's insurer to recover for injuries or damage in the event of any loss or injury and that Customer releases and waives all right of recovery against Company arising by way of subrogation. Company makes no guaranty or Warranty, including any implied warranty of merchantability or fitness for a particular purpose that equipment or services supplied by Company will detect or avert occurrences or the consequences therefrom that the equipment or service was designed to detect or avert.

It is impractical and extremely difficult to fix the actual damages, if any, which may proximately result from failure on the part of Company to perform any of its obligations under this agreement. Accordingly, Customer agrees that, Company shall be exempt from liability for any loss, damage or injury arising directly or indirectly from occurrences, or the consequences therefrom, which the equipment or service was designed to detect or avert. Should Company be found liable for any loss, damage or injury arising from a failure of the equipment or service in any respect, Company's liability shall be limited to an amount equal to the agreement price (as increased by the price for any additional work) or where the time and material payment term is selected, Customer's time and material payments to Company. Where this agreement covers multiple sites, liability shall be limited to the amount of the payments allocable to the site where the incident occurred. Such sum shall be complete and exclusive. If Customer desires Company to assume greater liability, the parties shall amend this agreement by attaching a rider setting forth the amount of additional liability and the additional amount payable by the Customer for the assumption by Company of such greater liability, provided however that such rider shall in no way be interpreted to hold Company as an insurer. IN NO EVENT SHALL COMPANY BE LIABLE FOR ANY DAMAGE, LOSS, INJURY, OR ANY OTHER CLAIM ARISING FROM ANY SERVICING, ALTERATIONS, MODIFICATIONS, CHANGES, OR MOVEMENTS OF THE COVERED SYSTEM(S) OR ANY OF ITS COMPONENT PARTS BY THE CUSTOMER OR ANY THIRD PARTY. COMPANY SHALL NOT BE LIABLE FOR INDIRECT, INCIDENTAL OR CONSEQUENTIAL DAMAGES OF ANY KIND, INCLUDING BUT NOT LIMITED TO DAMAGES ARISING FROM THE USE, LOSS OF THE USE, PERFORMANCE, OR FAILURE OF THE COVERED SYSTEM(S) TO PERFORM. The limitations of liability set forth in this agreement shall inure to the benefit of all parents, subsidiaries and affiliates of Company, whether direct or indirect, Company's employees, agents, officers and directors.

2. Limited Warranty. COMPANY WARRANTS THAT ITS WORKMANSHIP AND MATERIAL FURNISHED UNDER THIS AGREEMENT WILL BE FREE FROM DEFECTS FOR A PERIOD OF NINETY (90) DAYS FROM THE DATE OF FURNISHING. Where Company provides product or equipment of others, Company will warrant the product or equipment only to the extent warranted by such third party. EXCEPT AS EXPRESSLY SET FORTH HEREIN, COMPANY DISCLAIMS ALL WARRANTIES, EXPRESS OR IMPLIED, INCLUDING BUT NOT LIMITED TO ANY IMPLIED WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE WITH RESPECT TO THE SERVICES PERFORMED OR THE PRODUCTS, SYSTEMS OR EQUIPMENT, IF ANY, SUPPORTED HEREUNDER. COMPANY MAKES NO WARRANTY OR REPRESENTATION, AND UNDERTAKES NO OBLIGATION TO ENSURE BY THE SERVICES PERFORMED UNDER THIS AGREEMENT, THAT COMPANY'S PRODUCTS OR THE SYSTEMS OR EQUIPMENT OF THE CUSTOMER WILL CORRECTLY HANDLE THE PROCESSING OF CALENDAR DATES BEFORE OR AFTER DECEMBER 31, 1999.

3. Indemnity. Customer agrees to indemnify, hold harmless and defend Company against any and all losses, damages, costs, including expert fees and costs, and expenses including reasonable defense costs, arising from any and all third party claims for personal injury, death, property damage or economic loss, including specifically any damages resulting from the exposure of workers to Hazardous Conditions whether or not Customer pre-notifies Company of the existence of said hazardous conditions, arising in any way from any act or omission of Customer or Company relating in any way to this agreement, including but not limited to the Services under this agreement, whether such claims are based upon contract, warranty, tort (including but not limited to active or passive negligence), strict liability or otherwise. Company reserves the right to select counsel to represent it in any such action.

4. Hazardous Materials. Customer represents that, except to the extent that Company has been given written notice of the following hazards prior to the execution of this agreement, to the best of Customer's knowledge there is no:

- "permit confined space," as defined by OSHA, or space in which work must be performed that, because of its construction, location, contents or work activity therein, accumulation of a hazardous gas, vapour, dust or fume or the creation of an oxygen-deficient atmosphere may occur,
- risk of infectious disease,
- need for air monitoring, respiratory protection, or other medical risk,
- asbestos, asbestos-containing material, formaldehyde or other potentially toxic or otherwise hazardous material contained in or on the surface of the floors, walls, ceilings, insulation or other structural components of the area of any building where work is required to be performed under this agreement.

All of the above are hereinafter referred to as "Hazardous Conditions". Company shall have the right to rely on the representations listed above. If hazardous conditions are encountered by Company during the course of Company's work, the discovery of such conditions shall constitute an event beyond Company's control and Company shall have no obligation to further perform in the area where the hazardous conditions exist until the area has been made safe by Customer as certified in writing by an independent testing agency, and Customer shall pay disruption expenses and re-mobilization expenses as determined by Company. This agreement does not provide for the cost of capture, containment or disposal of any hazardous waste materials, or hazardous materials, encountered in any of the Covered System(s) and/or during performance of the Services. Said materials shall at all times remain the responsibility and property of Customer. Company shall not be responsible for the testing, removal or disposal of such hazardous materials.

5. Equipment Disconnections. This represents Company's notice to you that the system(s)/device(s) listed on the face of this agreement as temporarily or permanently disconnected are no longer in service and, thus, cannot detect, perform and/or report occurrences or transmit signals.

6. General. Unless otherwise specified, work shall be done between the hours of 8:00 AM and 5:00 PM, exclusive of Saturdays, Sundays and Company holidays. All work is subject to review and rebilling in accordance with the terms and conditions of Customer's agreement/contract with Company, if one is in effect. Company shall not be responsible for failure to render services due to causes beyond its control, including but not limited to material shortages, work stoppages, fires, civil disobedience or unrest, severe weather, fire or any other cause beyond the control of Company. Customer is aware that the Limitation of Liability and other provisions set forth in any existing agreement/contract, if one is in effect, or set forth above, apply to services performed and materials supplied. The terms of this agreement shall govern notwithstanding any inconsistent or additional terms and conditions in any purchase order or other document submitted by Customer.

4251

AMERICAN WATER

Plaza 3

RETURN THIS TEST FORM TO:

Tennessee American Water

Fax: 423-267-9384 Contact Phone: 423-771-4701 Email: tawc.crossconnection@amwater.com
Mail: Attention: Cross Connection Department 1101 Broad St. , Chattanooga, TN 37402

Account No. : **26-0105733-0**

Premise No. : **260074047**

LOCATION INFORMATION
Service For: Parkridge Medical Center

Address 1: 2333 McCallie Ave #fs
Address 2: Chattanooga, TN37404-3258
Type of Service: Domestic ☐ Fire ☑ Irrigation ☐
Location of Device: Fire Service
New Assembly ☐ Replaces Serial No: _____

DEVICE INFORMATION
Type of Assembly: Double Check Detector Backflow Prevention Assembly
Serial :N20020H0 330 Size : 8.00
MFG/Model No: AMES /3000ss
Water Meter No: None
Isolation ☐ Containment ☐

TEST MEASUREMENTS

	DC		RP	PVB/SVB
	Check Valve #1	Check Valve #2	Pressure Diff. Relief Valve	Air Inlet
Initial Date: 6-12-13 Time: 11:00 Am Line pressure: 75 psi	Held at 1.4 PSID Closed Tight ☑ Leaked ☐	Held at 1.4 PSID Closed Tight ☑ Leaked ☐ #2 Shut Off Valve Closed Tight? Yes ☑ No ☐	Opened at _____ PSID Did Not Open ☐	Opened at _____ PSID Did Not Open ☐ Check Valve Held _____ PSID
Final Date: _____ Time: _____ Line pressure: _____	Held at _____ PSID Closed Tight ☐ Leaked ☐	Held at _____ PSID Closed Tight ☐ Leaked ☐ #2 Shut Off Valve Closed Tight? Yes ☐ No ☐	Opened at _____ PSID Did Not Open ☐	Opened at _____ PSID Did Not Open ☐ Check Valve Held _____ PSID
AIR GAP	Measured vertical inches above overflow rim		Supply size diameter	

COMMENTS (including maintenance performed)

TESTER INFORMATION

INITIAL **PASS** ☑ **FAIL** ☐	Tester Name Steve Coleman	Company Chase
	Phone # 423-709-7237	Email Address
	Signature	Certified Tester No.: 8214
	Testing Equipment Calibration Date: 04-22-13	Testing Equipment Serial Number: 04111465
FINAL **PASS** ☐ **FAIL** ☐	Tester Name	Company
	Phone #	Email Address
	Signature	Certified Tester No.:
	Testing Equipment Calibration Date:	Testing Equipment Serial Number:

Want to save a stamp? Send your completed form electronically to tawc.crossconnection@amwater.com.
BACKFLOW TEST FORM - TO BE COMPLETED BY A QUALIFIED TESTER
The above report is certified to be true at the time of the test
Please return completed form by Saturday, June 15, 2013

E-MAILED 6-17-13 ff

QIC45C

CCNTEST1

007373 022110

58734250

18/06 2014 16:37 FAX 0029/0029

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
7175 STRAWBERRY PLAINS PIKE, SUITE 103
KNOXVILLE, TN 37914

June 5, 2014

Ms. Kristi Ballard, R.N., Administrator
Digestive Disorders Endoscopy Center
2341 McCallie Avenue, Plaza 3, Suite 303
Chattanooga, TN 37404

Dear Ms. Ballard:

Enclosed is the Statement of Deficiencies developed as the result of the survey conducted at Digestive Disorders Endoscopy Center on May 27 - 29, 2014.

In accordance with CFR Title 42 §488.28(b), you are requested to submit a Plan of Correction within ten (10) calendar days after receipt of this letter with acceptable time frames for correction of the cited deficiencies. Corrective action should be achieved no later than **July 13, 2014**, the 45th day from the date of the survey. Please notify this office when these deficiencies are corrected. A revisit may be conducted to verify compliance. Once corrective action is confirmed, a favorable recommendation for recertification will be considered.

Your POC must contain the following:

- What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice;
- How you will identify other patients having the potential to be affected by the same deficiency practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Please remember the administrator's signature and date signed must be on the appropriate line at the bottom of form CMS 2567 Statement of Deficiencies/Plan of Correction. Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

Should you have any questions or if there is any way this office may be of assistance, please do not hesitate to call.

Sincerely,

Karen B. Kirby, R.N.
Regional Administrator
East TN Health Care Facilities

KBK:cvb

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44C0001076	A. BUILDING _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGESTIVE DISORDERS ENDOSCOPY	2341 MCCALLIE AVE, SUITE 303 CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 241	416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. This STANDARD is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to follow infection control techniques during glucose monitoring for one patient (#21) of one patient observed. The findings included: Observation on May 28, 2014, at 12:00 p.m., at the nurses' station, revealed Registered Nurse (RN) #1 obtained a glucometer (device used to monitor blood sugar) from a drawer at the nurses' station, entered patient #21's room, stuck the patient's finger with a lancet (a pricking needle), obtained a drop of blood from patient #21's finger, placed the blood on a glucose strip, inserted the glucose strip in the glucometer, and after obtaining the blood sugar result RN #1exited patient #21's room, and without cleaning the glucometer RN #1 placed the glucometer back in the drawer at the nurses' station. Review of facility policy, Blood Glucose Monitors Competency In Use-Quality Control-Cleaning, last reviewed on August 10, 2012, revealed "...cleaning with the appropriate disinfectant is performed following each use..."	Q 241	416.51 (a) SANITARY ENVIRONMENT PLAN OF CORRECTION; The Center will provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. SYSTEMIC CHANGES: All staff have been advised cleaning of the patient care equipment including the glucometer shall be based on following manufacturer's and FDA recommendations. Patient care equipment cleaning processes were reviewed with staff. (Attachment A) MONITORING AND RESPONSIBILITY: The Center Director is responsible for adherence to the Infection Control Program including cleaning of patient care equipment and the prevention of cross contamination. Monitoring of the cleaning of patient care equipment will be based on observation, interviews with staff, and surveillance of cleaning practice. Each variance will be addressed with the individual at the time of occurrence and tracked in a blinded report for trending. Trended behavior will be addressed individually for causes. If needed, additional training will occur. Results of cleaning the glucometer monitoring will be reported to the QAPI Committee with results and recommendations submitted to the Governing Body for review and reporting.	6/16/2014
	Interview with RN #1 on May 28, 2014, at 12:08 p.m., at the nurses' station, confirmed RN #1 did not clean the glucometer after use and the facility policy was not followed.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44C0001076	A. BUILDING _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGESTIVE DISORDERS ENDOSCOPY	2341 MCCALLIE AVE, SUITE 303 CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53598	A. BUILDING: _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGESTIVE DISORDERS ENDOSCOPY	2341 MCCALLIE AVE, SUITE 303 CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 607	1200-8-10-.06 (1)(g) Basic Services (1) Surgical Services. (g) Qualified registered nurses may perform circulating duties in the operating room. In accordance with applicable State laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide an operating room circulator (circulating nurse) in two of two procedure rooms. The findings included: Observations on May 27-29, 2014, revealed the surgery center had two procedure rooms in use for Endoscopy (examination of gastrointestinal tract) procedures. Continued observation revealed facility staff present in each of the procedure rooms included a Physician, a Certified Registered Nurse Anesthetist (CRNA), and an Endoscopy Technician, who was assisting the Physician with the procedure. Further observation revealed the Surgical Technicians were not directly supervised by a Registered Nurse. Interview on May 29, 2014, at 11:30 a.m., in the conference room, with the facility Administrator, revealed "...I am the back-up if there are any issues, they can call me...also can use the pre-op or post-op nurse...can call any of us..." Continued interview confirmed the Endoscopy Technicians were not directly supervised by a Registered Nurse and there was not a circulating nurse in the	A 607	1200-8-10-06 (1)(g) BASIC SERVICES Qualified registered nurses may perform circulating duties in the operating room. In accordance with applicable State laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies. PLAN OF CORRECTION: Care provided to each patient at the Center will be appropriate based on patient assessment, State and federal regulations, and ASGE (American Society of Gastrointestinal Endoscopy) organization guidelines. The staffing patterns are based on the needs of the Center. The Center will develop a staffing ratio that provides the skill level necessary to promote optimum patient outcomes and efficient patient flow. The staffing plan will integrate the registered nurse in the supervisory role who will be immediately available and accommodate for skill diversity in the assistive role. The organization will provide additional RN resources when necessary. SYSTEMIC CHANGES: All staffing rules and guidelines for endoscopy have been reviewed by the Center Director and the leadership team. Constant adherence will be an ongoing expectation. The Center will recruit and train additional registered nurses to function in the supervisory role. RESPONSIBLE PARTY AND MONITORING: The Center Director will review all assignments daily for compliance. Issues of noncompliance will be reviewed with all parties involved. If 100% of the reviews demonstrate compliance, the review will become random. The results of these reviews will be tabulated and presented to the QAPI committee on a quarterly basis for review and recommendations. Recommendations will be presented to the Governing Body quarterly for review and approval.	6/20/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44C0001076	A. BUILDING 01 - 1 B. WING	05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGESTIVE DISORDERS ENDOSCOPY	2341 MCCALLIE AVE, SUITE 303 CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations and record review on 5/28/14, it was determined the facility failed to comply with the applicable codes. The findings included: 1. Records review on 5/29/14 at 11:00 AM revealed the facility failed to conduct the five year sprinkler guage inspection/ re-calibration/ replacement. The last time it was conducted was in 2006. National Fire Protection Association (NFPA) 25 Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems Table 5.1 2. Observation in the exit hallway by the offices on 5/28/14 at 11:13 AM revealed a smoke detector within three feet of an air supply. NFPA 72 National Fire Alarm Code 5.7.4.1 These findings were acknowledged by the facility during the exit conference on 5/28/14.	K 130	416.44(b)(1)LIFE SAFETY CODE STANDARD PLAN OF CORRECTION: The facility will inspect, test and maintain the automatic sprinkler system in accordance with NFPA 25. The sprinkler gauge inspection/re-calibration/ replacement will be maintained every five years. SYSTEMIC CHANGES: 1) The Center Director has contracted with a Sprinkler Inspection company who will conduct the five year inspection/re-calibration/ replacement. The inspection will be completed now and in five years. The records are now in the Center. 2) The smoke detector has been moved an additional three feet from the air supply. (Attachment B) RESPONSIBLE PARTY & MONITORING: It is the responsibility of the Center Director to ensure the facility is in compliance with the Life Safety Code Standards. The Center Director or designee will ensure that the Sprinkler System is inspected as required. The Center Director will report the results to the QAPI Committee for review and recommendation. Recommendations will be submitted to the Governing Body for review and approval.	7/13/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53598	A. BUILDING: 01 - 1 B. WING _____	05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGESTIVE DISORDERS ENDOSCOPY	2341 MCCALLIE AVE, SUITE 303 CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies Based on observations, testing, and records review on 5/28/14, it was determined the facility was in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board of Licensing Health Care Facilities and Chapter 1200-08-10 Standards For Ambulatory Surgery Centers.	A 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

AAAHC - Standard Survey Report

2014 AAAHC Survey Report

The Chattanooga Endoscopy ASC, LLC

DBA: Digestive Disorder Endoscopy Center

Organization ID: 83973

Chattanooga, Tennessee

February 10, 2015 to February 10, 2015

Information Regarding the AAAHC Survey Report

This *Survey Report* is used in conjunction with the *2014 Accreditation Handbook for Ambulatory Health Care*. This Survey Report reflects an evaluation of the organization's compliance with the standards as stated in the *Handbook*.

Evaluation of the Standards

SC -- Substantial Compliance indicates that the organization's current operations are acceptable and meet the standards. May require supporting comments to clarify or elaborate.
PC -- Partial Compliance indicates that a portion of the item is acceptable, but other areas need to be addressed. Requires supporting comments.
NC -- Non-Compliance indicates that the organization's current operations do not meet the standards. Requires supporting comments.
N/A -- Not Applicable indicates that the standard does not apply to the organization.

5250 Old Orchard Road, Suite 200
Skokie, IL 60077

Internet: www.aaahc.org
E-Mail: info@aaahc.org

The pronouns used in the Survey Report were chosen for the ease of reading. They are not intended to exclude reference to either gender.

Previous Deficiencies

Chapter	Standard	Previous Compliance Level	Previous Comment	Current Compliance Level	Current Comment	Deficiency Comment
1 - Rights of Patients	F-2	PC	Disclosure of certain patient responsibilities has not been addressed. See comment at Standard G. The organization is in the process of amending the rights and responsibilities to be more comprehensive and inclusive of the required standards.	SC	The patient's responsibility to participate in their health care treatment was not included in last survey, but now is included.	
1 - Rights of Patients	G	PC	Though patients are given a list of responsibilities before their procedure, this list is incomplete. See comments at Standards G-2, G-3, and G-4. The organization is in the process of amending the list of rights and responsibilities.	SC	Patient responsibilities have been revised since the last survey and include the elements of this Standard.	
1 - Rights of Patients	G-2	NC	The written list of patient responsibilities does not include to follow the prescribed course of treatment or participate in his/her care. The new form, which is not in circulation yet, contains this information.	SC	This element of this Standard was added to the patient's rights since last survey.	
1 - Rights of Patients	G-3	PC	This information is told to patients verbally prior to their procedure, but is currently not listed as one the patient responsibilities on the written document. The new form, which is not in circulation yet, contains this information.	SC	The patient's responsibility to provide an adult to transport them home after receiving sedation was added to the list since the last survey.	
1 - Rights of Patients	G-4	NC	Though patients are informed of their right to an advance directive, they are not informed of the responsibility to inform their provider about it.			
4 - Quality of Care	E-4	PC	Medications are incompletely documented on half of the records reviewed. See comment at	SC	A medication reconciliation form was created to satisfy the	

			Standard 6.L-7.		partial compliance from the last survey. The director held an in-service a few weeks ago to instruct the staff on how to complete the form. Credit was given for complete medication reconciliation during chart review if the doses and frequencies were documented on the H&P. 8/10 charts had documentation.	
4 - Quality of Care	G	PC	Clinical record entries lack documentation of untoward reactions to allergies on all charts reviewed with an allergy listed. Customized discharge instructions lack post-anesthesia precautions. There is incomplete documentation of medications and dosages on 80% of the records reviewed.			
6 - Clinical Records	K	PC	Untoward reactions were not documented on any records reviewed with listed allergies. Otherwise, allergies were documented consistently on all records.	SC	A new medication reconciliation form was implemented. The right hand column is where the allergy and reactions were documented on all 10 charts reviewed for the survey.	
6 - Clinical Records	L-7	PC	Medications were reconciled with dosages on only 50% of the records reviewed. The rest contained the names of medication with no further documentation.	SC	The director implemented a medication reconciliation form. She thought the nurses understood how to complete them, but when the medical record review was completed for the survey, the nurses placed their initials and date by the medications, but still	

					did not add the doses and frequencies. The director had to conduct another in-service to show them that doses and frequencies had to be documented. Credit was given for doses and frequencies on 7/10 charts during the survey, because the physicians had listed them on their current H&P.	
6 - Clinical Records	L-8	PC	Discharge instructions contained information relevant to endoscopy only. There were no precautions given for post-anesthesia care.	SC		
9 - Anesthesia Srvcs	G-4	PC	At this time, the organization does not have monitoring equipment for end-tidal CO2.	SC		
9 - Anesthesia Srvcs	J	PC	The CRNA had the patient monitored for EKG, blood pressure, and pulse oximetry. The organization does not have the equipment to monitor end-tidal CO2 and most patients receive deep sedation or general anesthesia with propofol.	SC	New Mindray monitoring machines were purchased to include all of the above monitoring, including ET CO2, which they did not monitor for the last survey.	
9 - Anesthesia Srvcs	K	PC	The organization maintains a detailed written policy for the management of pain. The policy states that assessment uses a one to ten numerical scale or a visual analog scale. However, documentation on the medical record actually uses a one to two pain assessment scale.	SC		
9 - Anesthesia Srvcs	X	PC	See comment at Standard X-1.	SC		
9 - Anesthesia Srvcs	X-1	NC	End-tidal CO2 monitoring is not done for all patients receiving propofol. The organization has been discussing the purchase of	SC	Refer to Standard 9.K.	

			monitors for the past year and a half. They have been researching different models and have not found one yet that they like. It is in their budget for this year to purchase monitors for both procedure rooms.			
10 - Surg Gen Srvcs I	D	PC	Only two of ten clinical records reviewed had complete history and physical reports on them. The other eight of ten were missing medication documentation.	SC	A complete history and physical was reviewed on each of the 10 charts for the survey. They included a complete list of medications, doses, and frequency, within the 30 day window.	
10 - Surg Gen Srvcs I	Y	PC	See comment at Standard 6.L-8.	SC	Patients are given discharge instructions and a copy is in the chart. Anesthesia discharge instructions have now been included, a correction from the previous survey.	
11 - Pharmaceutical Srvcs	E	PC	See comment at Standard 6.L-7	SC		

Satellite Facilities Overview			
Standard		**Compliance Rating**	**Comments**
1	Does the organization have more than one facility?	No	
2	If the organization has more than one facility, list those that are to be included in the accreditation.		
3	List the names and addresses of the satellite location that were reviewed.		
4	Provide a brief description of the satellite locations reviewed during the survey, including information on the quality of care rendered, clinical records, and facilities and environment. If applicable, also include information on pharmaceutical services, pathology and medical laboratory services, diagnostic and therapeutic imaging, occupational health services, surgical services, and anesthesia services.		

Chapter 1 - Patient Rights and Responsibilities

Standard		Compliance Rating	Comments
	An accreditable organization recognizes the basic human rights of patients. Such an organization has the following characteristics.		
	Overall Chapter Compliance Level	SC	
A	Patients are treated with respect, consideration, and dignity.	SC	Patients are treated with respect and compassion by a friendly team at Digestive Disorder Endoscopy Center.
B	Patients are provided appropriate privacy.	SC	All staff members sign confidentiality statements and all HIPAA regulations are adhered to. Curtains provide privacy in prep and post procedure. The areas are distinguished from one another; one has solid colored curtains and the other has patterns.
C	When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.	SC	
D	Patients are provided, to the degree known, information concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.	SC	
E	Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.	SC	
F	Information is available to patients and staff concerning:	SC	Patient rights and responsibilities are posted along with grievance information and statement of ownership.
F.1	Patient rights, including those specified in A, B, C, D, and E above.	SC	
F.2	Patient conduct, responsibilities, and participation.	SC	The patient's responsibility to participate in their health care treatment was not included in last survey, but now is included.
F.3	Services available at the organization.	SC	The center only provides gastroenterology services.
F.4	Provisions for after-hours and emergency care.	SC	
F.5	Fees for services.	SC	

F.6	Payment policies.	SC	
F.7	Patient's right to refuse to participate in research.	NA	Research is not conducted in the center.
F.8	Advance directives, as required by state or federal law and regulations.	SC	The patient rights were revised from last survey to include the right to advise their physician of their advance directives.
F.9	The credentials of health care professionals.	SC	
F.10	The absence of malpractice coverage if applicable.	NA	All physicians have malpractice insurance.
F.11	How to voice grievances regarding treatment or care that is (or fails to be) furnished.	SC	
F.12	Methods for providing feedback, including complaints.	SC	
G	Prior to receiving care, patients are informed of patient responsibilities. These responsibilities require the patient to:	SC	Patient responsibilities have been revised since the last survey and include the elements of this Standard.
G.1	Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.	SC	Patients are queried regarding current medications, over the counter drugs, supplies, and alternative medications. A new form was instituted to reconcile medications.
G.2	Follow the treatment plan prescribed by his/her provider and participate in his/her care.	SC	This element of this Standard was added to the patient's rights since last survey.
G.3	Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her provider.	SC	The patient's responsibility to provide an adult to transport them home after receiving sedation was added to the list since the last survey.
G.4	Accept personal financial responsibility for any charges not covered by his/her insurance.	SC	
G.5	Be respectful of all the health care professionals and staff, as well as other patients.	SC	
H	Patients are informed of their right to change providers if other qualified providers are available.	SC	
	Consultative Comments		**Consultative Comments**

Chapter 2 - Governance - General Requirements I			
Standard		**Compliance Rating**	**Comments**
	An accreditable organization has a governing body that sets policy and is responsible for the organization. Such an organization has the following characteristics.		
	Overall Chapter Compliance Level	SC	
	Subchapter I - General Requirements: This subchapter describes general requirements for an organization and its governing body.	SC	
A	The organization is a legally constituted entity, or an organized sub-unit of a legally constituted entity, or is a sole proprietorship in the state(s) in which it is located and provides services.	SC	The Chattanooga Endoscopy Center, ASC, LLC (DBA Digestive Disorder Endoscopy Center) is a limited liability company.
A.1	A legally constituted entity is documented by at least one of the following: articles of organization, articles of incorporation, partnership agreement, operating agreement, legislative or executive act, or bylaws, unless the organization is a sole proprietorship.	SC	
B	The names and addresses of all owners or controlling parties (whether individuals, partnerships, trusts, corporate bodies or subdivisions of other bodies, such as public agencies or religious, fraternal, or other philanthropic organizations) are available upon request and furnished to the Accreditation Association for Ambulatory Health Care, Inc (AAAHC).	SC	AmSurg of Nashville, Tennessee, owns 51% of the center. Chattanooga Gastroenterology, P.C. owns 24.5%, Gastroenterology Associates of Chattanooga, P.C. owns 18.72%, and Dr. Henry Paik owns 5.78%.
C	The governing body addresses and is fully and legally responsible, either directly or by appropriate professional delegation, for the operation and performance of the organization. Governing body responsibilities include, but are not limited to:	SC	The governing body consists of two representatives of AmSurg, and two physicians representing the Center, one being the Medical Director. The Board's responsibilities include the elements of this Standard.
C.1	Determining the mission, goals, and objectives of the organization.	SC	The mission and goals are well defined and understood by the staff.
C.2	Ensuring that facilities and personnel are adequate and appropriate to carry out the mission.	SC	
C.3	Establishing an organizational structure and specifying functional relationships among the various components of the organization.	SC	
C.4	Adopting bylaws or similar rules and regulations for the orderly development and management of the organization.	SC	
C.5	Adopting policies and procedures necessary for the orderly conduct of the	SC	

	organization, including the organization's scope of clinical activities.		
C.6	The organization defines pediatric patients and develops and maintains a policy defining the care of pediatric patients, if relevant; specific components of perioperative care are listed in Standard 10.I.AA.	NA	Pediatric patients are not treated in this center.
C.7	Ensuring that the quality of care is evaluated and that identified problems are appropriately addressed.	SC	
C.8	Reviewing all legal and ethical matters concerning the organization and its staff and, when necessary, responding appropriately.	SC	
C.9	Maintaining effective communication throughout the organization, including ensuring links between quality management and improvement activities and other management functions of the organization.	SC	
C.10	Establishing a system of financial management and accountability appropriate to the organization.	SC	
C.11	Determining a policy on the rights and responsibilities of patients.	SC	
C.12	Approving and assuring compliance of all major contracts or arrangements affecting the medical and dental care provided under its auspices and ensuring that services are provided in a safe and effective manner, including, but not limited to, those concerning:	SC	The governing body approves all contracts.
C.12.a	The employment or contracting of health care professionals.	SC	
C.12.b	The provision of external services for radiology, pathology, medical laboratory and housekeeping services.	SC	There are contracts in place for the above services.
C.12.c	The provision of care by other health care organizations, such as hospitals.	SC	
C.12.d	The provision of education to students and postgraduate trainees.	NA	Students are not educated in the center.
C.12.e	The provision of after-hours patient information or telephone triage services, including the review of protocols.	SC	
C.12.f	The Centers for Medicare & Medicaid Services (CMS) requirements, if the organization participates in the Medicare/Medicaid program.	SC	
C.12.g	The activities or services delegated to another entity.	SC	
C.13	Formulating long-range plans in accordance with the mission, goals and objectives of the organization.	SC	The center is in the process of credentialing eleven new physicians to complete procedures in the center. This will involve utilizing the third procedure room, more staff, and schedule changes.

C.14	Fulfilling all applicable obligations under local, state, and federal laws and regulations, such as those addressing disabilities, medical privacy, grievances, fraud and abuse, self-referral, anti-trust, reporting to the National Practitioner Data Bank (NPDB)[1], etc.	SC	
C.15	Assuring that none of the marketing and advertising regarding the competence and capabilities of the organization is misleading.	SC	The marketing material represented the competence and capability of the center. It was very creative material, using the backside of animals to encourage colonoscopies. The slogan was "no butts about it."
C.16	Developing a program of risk management appropriate to the organization that includes review of risk management activities.	SC	
C.17	Determining a policy on continuing education for personnel and/or patient education for members/enrollees, if applicable.	SC	
C.18	Development, implementation and oversight of the organization's infection control and safety programs to ensure a safe environment of care.	SC	
D	Accredited organizations must notify the AAAHC in writing within 15 calendar days of significant organizational, ownership, operational or quality of care events, including criminal indictment, guilty plea or verdict in a criminal proceeding (other than a traffic violation) directly or indirectly involving the organization or any of its officers, administrators, physicians/health care professionals, or staff within their role in the organization. Any such change/event that negatively affects the public's perception of the accredited organization or AAAHC, as the accrediting body, must also be reported. An organization's duty to provide this information continues during the entire accreditation term.	SC	
E	Representation of accreditation to the public must accurately reflect the AAAHC-accredited entity.	SC	
F	The governing body meets at least annually, or more frequently as determined by the governing body and keeps such minutes or other records as may be necessary for the orderly conduct of the organization.	SC	The governing body meets quarterly, as evidenced by their minutes.
G	Items to be reviewed should include, but are not limited to:	SC	The Board's minutes were reviewed and include the following elements to satisfy this Standard. The Board functions as intended.
G.1	Rights of patients.	SC	
G.2	Delegated administrative responsibilities.	SC	
G.3	Quality of care.	SC	
G.4	The quality management and improvement program.	SC	

G.5	The organization's policies and procedures.	SC	
G.6	The appointment/reappointment process.	SC	
G.7	The infection control program.	SC	
G.8	The safety program.	SC	
G.9	Compliance with all other applicable Standards.	SC	
H	If the governing body elects, appoints, or employs officers and administrators to carry out its directives, the authority, responsibility, and functions of all such positions are defined. Consultative Comments	SC	 Consultative Comments
	[1]For information on the National Practitioner Data Bank, see http://www.npdb-hipdb.hrsa.gov		

Chapter 2 - Governance - Credentialing and Privileging II			
Standard		**Compliance Rating**	**Comments**
	Credentialing is a three-phase process of assessing and validating the qualifications of an individual to provide services. The objective of credentialing is to establish that the applicant has the specialized professional background that he or she claims and that the position requires. An accreditable organization: **1) establishes minimum training, experience and other requirements (i.e., credentials) for physicians and other health care professionals;** **2) establishes a process to review, assess, and validate an individual's qualifications, including education, training, experience, certification, licensure and any other competence-enhancing activities against the organization's established minimum requirements; and** **3) carries out the review, assessment, and validation as outlined in the organization's description of the process.**		
	Subchapter II - Credentialing and Privileging: This subchapter describes the requirements for credentialing and privileging of health care professionals to provide patient care in an accreditable organization. Organizations may find the *Worksheets and Forms* located in the back of this *Handbook* helpful in creating medical staff applications and in measuring compliance with credentials verification processes.	SC	
	Number of credential files reviewed during the survey:	3	
	Description of how records were selected:		The medical director's file, as well as a new physician, and a CRNA file were selected.
A	The medical staff must be accountable to the governing body. The governing body establishes and is responsible for a credentialing and reappointment process, applying criteria in a uniform manner to appoint individuals to provide patient care for the organization. The governing body approves mechanisms for credentialing, reappointment, and the granting of privileges, and suspending or terminating clinical privileges, including provisions for appeal of such decisions.	SC	
B	The governing body, either directly or by delegation, makes (in a manner consistent with state law) initial appointment, reappointment, and assignment or curtailment of clinical privileges of medical staff members based on professional peer evaluation. This process has the following characteristics:	SC	The credentialing files are complete with all of the required elements of this Standard.
B.1	The governing body has specific criteria for the initial appointment and reappointment of physicians and dentists.	SC	

B.2	Provisions are made for the expeditious processing of applications for clinical privileges.	SC	
B.3	On an application for initial credentialing and privileges, the applicant is required to provide sufficient evidence of training, experience, and current documented competence in performance of the procedures for which privileges are requested. At a minimum, the following credentialing and privileging information shall be provided for evaluation of the candidate:	SC	On initial credentialing, the physician is verified by Tennessee Dept. of Health Practitioner Profile and the AMA profile.
B.3.a	Education, training, and experience: Relevant education and training are verified at the time of appointment and initial granting of clinical privileges; the applicant's experience is reviewed for continuity, relevance, and documentation of any interruptions in that experience.	SC	
B.3.b	Peer evaluation: Current competence is verified and documented.	SC	
B.3.c	Current state license: Current licensure is verified and documented at the time of appointment.	SC	Current medical licenses and DEA registrations are present.
B.3.d	Drug Enforcement Administration (DEA) registration, if applicable.	SC	
B.3.e	Proof of current medical liability coverage meeting governing body requirements, if any.	SC	
B.3.f	Information obtained from the National Practitioner Data Bank (NPDB)[1]Note: The NPDB Proactive Disclosure Services (PDS) is an acceptable service for meeting the requirement for querying the NPDB (see Resources).	SC	The reports are present for the NPDB.
B.3.g	The organization requires, at initial appointment and reappointment, written attestation from the applicant addressing other pertinent information which includes, but need not be limited to:	SC	The application has a section which queries the elements of this Standard.
B.3.g.i	Professional liability claims history.	SC	
B.3.g.ii	Information on licensure revocation, suspension, voluntary relinquishment, licensure probationary status, or other licensure conditions or limitations.	SC	
B.3.g.iii	Complaints or adverse action reports filed against the applicant with a local, state, or national professional society or licensure board.	SC	
B.3.g.iv	Refusal or cancellation of professional liability coverage.	SC	
B.3.g.v	Denial, suspension, limitation, termination or nonrenewal of professional privileges at any hospital, health plan, medical group, or other health care entity.	SC	
B.3.g.vi	DEA and state license action.	SC	

B.3.g.vii	Disclosure of any Medicare/Medicaid sanctions.	SC	
B.3.g.viii	Conviction of a criminal offense (other than minor traffic violations).	SC	
B.3.g.ix	Current physical, mental health, or chemical dependency problems that would interfere with an applicant's ability to provide high-quality patient care and professional services.	SC	
B.3.g.x	Signed statement releasing the organization from liability and attesting to the correctness and completeness of the submitted information.	SC	
B.4	Upon completion of the application, the credentials are verified according to procedures established in the organization's bylaws, rules and regulations, or policies. The organization has established procedures to obtain information necessary for primary or secondary source verification of the credentials and is responsible for obtaining this information. An accreditable organization may use information provided by a Credentials Verification Organization (CVO) after proper assessment of the capability and quality of the CVO. Alternatively, a CVO may demonstrate such capability and quality by becoming accredited or certified by a nationally recognized accreditation organization. Primary or acceptable secondary source verification is required for items listed in 2.II.B-3a-f, unless a CVO or an organization performing primary source verification that is accredited or certified by a nationally recognized body is used. If the organization utilizes a CVO or another organization to verify credentials, those entities must perform primary source verification unless such sources do not exist or are impossible to verify.	SC	
B.5	Medical staff must apply for reappointment every three years, or more frequently if state law or organizational policies so stipulate. At reappointment, the organization requires completion of a reappointment application and verifies items listed in Standard 2.II.B-3c-g and peer review activities as described in subchapter III.	SC	The center reappoints their medical staff every 2 years, per policies. The medical director's appointment had expired 2 months prior. The director was able to obtain the re-credentialing information and re-appoint the medical director before the close of the survey.
B.6	The organization shall monitor and document the currency of date sensitive information such as licensure, professional liability insurance (if required), certifications, DEA registrations and other such items, where applicable, on an ongoing basis (at expiration, appointment, and re-appointment, at minimum.)	SC	
B.7	In a solo medical or dental practice, the provider's credentials file shall be reviewed by an outside physician (for a medical practice) or an outside dentist (for a dental practice) at least every three years, or more frequently, if state law or organizational policies so stipulate, to ensure currency, accuracy and completeness of credentials. The provider is required to complete an application or reapplication, and the documentation identified in Standard 2.II.B.3 must be present in the credentials file, including a list of procedures that will be performed by the provider in the organization/practice setting and evidence of appropriate education, training, and experience to perform the privileged procedures. Applications are available for other providers requesting credentialing and privileges to perform procedures in the solo provider's	NA	This is not a solo practice.

	organization, including any anesthesia providers. In a solo provider's practice, the granting of privileges shall be reviewed by an outside physician (for medical practices) or dentist (for dental practices) with documentation provided to the organization.		
	Privileging is a three-phase process. The objective of privileging is to determine the specific procedures and treatments that a health care professional may perform. An accreditable organization: 1) determines the clinical procedures and treatments that are offered to patients; 2) determines the qualifications related to training and experience that are required to authorize an applicant to obtain each privilege; and 3) establishes a process for evaluating the applicant's qualifications using appropriate criteria and approving, modifying, or denying any or all of the requested privileges in a non-arbitrary manner.		
C	The scope of procedures must be periodically reviewed by the governing body and amended as appropriate.	SC	
D	Privileges to carry out specified procedures are granted by the organization to the health care professional to practice for a specified period of time. The health care professional must be legally and professionally qualified for the privileges granted. These privileges are granted based on an applicant's qualifications within the services provided by the organization and recommendations from qualified medical personnel.	SC	
E	The organization has its own independent process of credentialing and privileging. The approval of credentials or the granting of privileges requires review and approval by the organization's governing body. Credentials may not be approved, nor privileges granted, solely on the basis that another organization, such as a hospital, approved credentials or granted privileges, without further review. Such status at another organization may be included in the governing body's consideration of the application.	SC	
F	The governing body provides a process (in a manner consistent with state law and based on evidence of education, training, experience, and current competence) for the initial appointment, reappointment, and assignment or curtailment of privileges and practice for allied health care professionals. Consultative Comments	SC	Consultative Comments
	[1]For information on the National Practitioner Data Bank, see http://www.npdb-hipdb.hrsa.gov		

Chapter 2 - Governance - Peer Review III			
Standard		**Compliance Rating**	**Comments**
	Subchapter III - Peer Review: An accreditable organization maintains an active and organized process for peer review that is integrated into the quality management and improvement program and is evidenced by the following characteristics:	SC	
A	The health care professionals understand, support, and participate in a peer review program through organized mechanisms that are consistent with the organization's policies and procedures, and are responsible to the governing body. The peer review activities are evidenced in the quality improvement program.	SC	
B	At least two physicians (or dentists in dental practices) are involved to provide peer-based review. (In solo physician or dental organizations, such as office-based surgical practices, independent practice associations, and dental practices, an outside physician or dentist is involved to provide peer-based review.)	SC	All four physicians provide peer review for the center. 5% of the physicians' charts are reviewed for peer review.
C	At least two health care professionals, one of whom may be a physician or dentist, are involved to provide peer-based review within their scope of practice for professionals such as nurse practitioners, certified registered nurse anesthetists, and physician assistants. Peer review as part of an employee's performance evaluation is acceptable.	SC	
D	The organization provides ongoing monitoring of important aspects of the care provided by physicians, dentists and other health care professionals. Monitoring important aspects of care is necessary for monitoring performance and establishing internal benchmarks.	SC	The organization monitors other aspects of care to include: infections, complications, transfers, hospital admissions, and adverse events.
E	Health care professionals participate in the development and application of the criteria used to evaluate the care they provide.	SC	
F	Data related to established criteria are collected in an ongoing manner and are periodically evaluated to identify acceptable or unacceptable trends or occurrences that affect patient outcomes.	SC	
G	The results of peer review activities are reported to the governing body.	SC	
H	The results of peer review are used as part of the process for granting continuation of clinical privileges, as described in Chapter 2.II.	SC	Peer review is one criteria used for re-credentialing.
I	To improve the professional competence and skill, as well as the quality of	SC	

	performance, of the health care professionals and other professional personnel it employs, the organization:		
I.1	Provides convenient access to reliable, up-to-date information pertinent to the clinical, educational, administrative, and research services provided by the organization.	SC	
I.2	Encourages health care professionals to participate in educational programs and activities, as demonstrated in the organization's policies or procedures; these educational programs may be internal or external, and are consistent with the organization's mission, goals, and objectives.	SC	
	Consultative Comments		Consultative Comments

Chapter 3 - Administration			
Standard		**Compliance Rating**	**Comments**
	An accreditable organization is administered in a manner that ensures the provision of high-quality health services and that fulfills the organization's mission, goals, and objectives. Organizations may find it helpful to use the *Personnel Records Worksheet* to evaluate compliance with some Standards found in this chapter. The Worksheets and Forms section is located in the back of this Handbook.		
	Overall Chapter Compliance Level	SC	
	Number of personnel files reviewed during the survey:	3	
	Description of how records were selected:		The records were selected to represent different job descriptions.
	An accreditable organization is administered in a manner that ensures the provision of high-quality health services and that fulfills the organization's mission, goals, and objectives. Organizations may find it helpful to use the *Personnel Records Worksheet*, found in the *Worksheets and Forms* section, to evaluate compliance with some Standards found in this chapter.		
A	Administrative policies, procedures and controls are established and implemented to ensure the orderly and efficient management of the organization. Administrative responsibilities include, but are not limited to:	SC	Policies are in place for management of the center.
A.1	Enforcing policies delegated by the governing body.	SC	
A.2	Employing qualified management personnel.	SC	Personnel files reflect that staff have the qualifications for their roles.
A.3	Taking all reasonable steps to comply with applicable laws and regulations.	SC	
A.4	Protecting the assets of the organization.	SC	
A.5	Implementing fiscal controls, including, but not limited to:	SC	The governing body, physicians, and AmSurg oversee the fiscal controls of the center.
A.5.a	Authorization and record procedures that are adequate to provide accounting controls over assets, liabilities, revenues and expenses.	SC	
A.5.b	Policies and procedures for controlling accounts receivable and accounts payable and for handling cash and credit arrangements.	SC	

A.5.c	Rates and charges for services provided by the organization.	SC	
A.5.d	Methods of collection of unpaid accounts that are reviewed before referral to a collection agency.	SC	
A.6	Using methods of communicating and reporting designed to ensure the orderly flow of information within the organization.	SC	
A.7	Controlling the purchase, maintenance, and distribution of the equipment, materials, and facilities of the organization.	SC	
A.8	Operating based on established lines of authority.	SC	
A.9	Establishing controls relating to the custody of the official documents of the organization.	SC	
A.10	Maintaining the confidentiality, security, and physical safety of data on patients and staff.	SC	
A.11	Maintaining a health information system that supports the collection, integration, and analysis of data and allows reporting as necessary.	SC	
A.12	Dealing with inquiries from governmental agencies, attorneys, consumer advocate groups, and the media.	SC	
B	Personnel policies are established and implemented to facilitate attainment of the mission, goals, and objectives of the organization. Personnel policies:	SC	Personnel policies are in place and staff receive a copy.
B.1	Define and delineate functional responsibilities and authority.	SC	
B.2	Require the employment of personnel with qualifications commensurate with job responsibilities and authority, including appropriate licensure or certification.	SC	Personnel files have signed and dated job descriptions.
B.3	Specify privileges and responsibilities of employment, including compliance with an adverse incident reporting system, as described in Standard 5.II.E.2-4.	SC	
B.4	Reflect the requirement for documentation of initial orientation and training according to position description. Initial orientation and training shall be:	SC	Detailed orientation checklists are present in all files. Excellent orientation is present that encompasses all required elements. Training is accessed through HealthStream.
B.4.a	Completed within 30 days of commencement of employment.	SC	
B.4.b	Provided annually thereafter and when there is an identified need.	SC	
B.5	Require periodic appraisal of each person's job performance, including current competence.	SC	Salaries and performance are reviewed annually.

B.6	Describe incentives and rewards, if any exist.	SC	
B.7	Require periodic review of employee compensation.	SC	
B.8	Are made known to employees at the time of employment.	SC	
B.9	Comply with federal and state laws and regulations regarding verification of eligibility for employment, such as I-9 (Immigration and Naturalization form) and visas, as required.	SC	I-9s are complete and kept in a separate file.
C	Health care workers are protected from biologic hazards, consistent with state, federal, and CDC guidelines. The organization has:	SC	
C.1	Approved and implemented policies that comply with all applicable occupational health and safety regulations for health care workers, such as the Occupational Safety and Health Administration (OSHA) rules on Occupational Exposure to Bloodborne Pathogens (Title 29 CFR 1910.1030) designed to eliminate and/or minimize employee exposures.	SC	All OSHA requirements are in place, including exposure control.
C.2	The organization has a written exposure control plan that is reviewed and updated at least annually, including an evaluation for the availability of safer medical devices and changes in technology.	SC	
C.3	The exposure control plan is made a part of employee initial orientation and retraining that is conducted within one year of their last training.	SC	
C.4	The organization has an effective program addressing blood borne pathogens, including:	SC	Staff have health files with documentation of Hepatitis B, TB, and other vaccines. Records of exposures and follow-up are also filed here.
C.4.a	Hepatitis B vaccination program.	SC	
C.4.b	Post-exposure evaluation and treatment.	SC	
C.4.c	Appropriate training in and communication of hazards to employees.	SC	
C.4.d	Appropriate record keeping and management.	SC	
C.5	An immunization program for other infectious agents of risk to health care workers and their patients.	SC	
C.6	A tuberculosis respiratory protection program.	SC	
C.7	Programs that address other relevant biological hazards, such as bioterrorism, as needed for employee safety and health.	SC	
D	A program is maintained to assess and reduce risks associated with occupational chemical exposures, including:	SC	

D.1	Hazard assessment of chemicals used in the workplace.	SC	
D.2	Engineering measures to reduce the risk of chemical exposure.	SC	
D.3	Worker training programs.	SC	
E	A program is maintained to assess, and where necessary, reduce risks associated with physical hazards, such as ergonomic exposures, violence at the workplace, and external physical threats such as terrorism.	SC	In-services are conducted on ergonomics, workplace violence, and terrorism through HealthStream.
F	Records of work injuries or illnesses are maintained, consistent with reporting requirements, and employee health records are managed appropriately.	SC	
G	The organization periodically assesses patient satisfaction with services and facilities provided by the organization. The findings are reviewed by the governing body and, when appropriate, corrective actions are taken.	SC	
H	When students and postgraduate trainees are present, their status is defined in the organization's written policies and procedures. Consultative Comments	NA	Students are not trained in the center. Consultative Comments

Chapter 4 - Quality of Care Provided			
Standard		Compliance Rating	Comments
	An accreditable organization provides high-quality health care services in accordance with the principles of professional practice and ethical conduct, and with concern for the costs of care and for improving the community's health status. Such an organization has the following characteristics.		
	Overall Chapter Compliance Level	SC	The organization provides excellent care as evidenced by referrals, outcomes, patient satisfaction, and peer review.
A	All health care professionals have the necessary and appropriate training and skills to deliver the services provided by the organization.	SC	The physicians are Board certified and credentialed. They have hospital privileges.
B	Health care professionals practice their professions in an ethical and legal manner.	SC	
C	All personnel assisting in the provision of health care services are appropriately qualified and supervised and are available in sufficient numbers for the care provided.	SC	Sufficient numbers of trained staff were available on tour of facility, and as evidenced by personnel files. PRN staff are hired to provide back-up services.
D	The organization has a current and comprehensive written quality management and improvement program.	SC	
E	The organization facilitates the provision of high-quality health care as demonstrated by the following:	SC	The center provides peer review, and assesses the quality of care via patient satisfaction surveys, outcomes, QI studies, benchmarking, and chart audits.
E.1	Health care provided is consistent with current standard of care.	SC	
E.2	Education of and effective communication with patients served concerning the diagnosis and treatment of their conditions, appropriate preventive measures, and use of the health care system.	SC	
E.3	Appropriate and timely diagnosis based on findings of the current history and physical examination.	SC	
E.4	Medication reconciliation is performed.	SC	A medication reconciliation form was created to satisfy the partial compliance from the last survey. The director held an in-service a few weeks ago to instruct the staff on how to complete the form. Credit was given for complete medication reconciliation during chart review if the doses and frequencies were documented on the H&P. 8/10 charts had documentation.
E.5	Treatment that is consistent with clinical impression or working diagnosis.	SC	

E.6	Appropriate and timely consultation and referrals.	SC	
E.7	When clinically indicated, patients are contacted as quickly as possible for follow-up regarding significant problems and/or abnormal findings.	SC	
E.8	Continuity of care and patient follow-up.	SC	
E.9	Assessing patient satisfaction and taking corrective actions, when indicated.	SC	
E.10	The use of performance measures to improve outcomes.	SC	
F	Health services available at the organization are accessible to patients and ensure patient safety by at least the following:	SC	
F.1	Provision for and information about services when the organization's facilities are not open.	SC	
F.2	Adequate and timely transfer of information when patients are transferred to other health care professionals.	SC	When patients are transferred to other specialists, a reference letter and other appropriate information are sent.
G	The organization has policies and procedures for identifying, storing, and transporting laboratory specimens and biological products. The policies and procedures include logging and tracking to ensure that results for each specimen are obtained and have been reported to the ordering physician in a timely manner.	SC	
H	When the need arises, the organization assists patients with the transfer of their care from one health care professional to another.	SC	
H.1	Adequate specialty consultation services are available by prior arrangement.	SC	
H.2	Referral to another health care professional is clearly outlined to the patient and arranged with the accepting health care professional.	SC	
I	When emergencies or unplanned outcomes occur, and hospitalization is indicated for the evaluation and stabilization of the patient, the organization shall have one of the following in place:	SC	
I.1	A written transfer agreement for transferring patients to a nearby hospital.	SC	Written transfer agreements were in place for Health Care System and Parkridge Medical Center.
I.2	A written policy of credentialing and privileging physicians and dentists who have admitting and similar privileges at a nearby hospital.	SC	
I.3	Written agreement with a physician or provider group with admitting privileges at a nearby hospital.	SC	

I.4	A detailed written procedural plan for handing medical emergencies.	SC	
J	Concern for the costs of care is present throughout the organization.	SC	The center is very aware of the cost of care and uses the least expensive alternatives. A QI study was conducted on the high cost of supplies and how to reduce it.
	Consultative Comments		Consultative Comments

Chapter 5 - Quality Management and Improvement - Quality Improvement Program I			
Standard		**Compliance Rating**	**Comments**
	In striving to improve the quality of care and to promote more effective and efficient utilization of facilities and services, an accreditable organization maintains an active, integrated, organized, ongoing, data-driven, peer-based program of quality management and improvement that links peer review, quality improvement activities, and risk management in an organized, systematic way. Organizations may also find it useful to refer to *Analyzing Your Quality Management Program and Creating Meaningful Studies* in the *Worksheets and Forms* section of this Handbook.		
	NOTE: The intent of this chapter is that administrative and clinical personnel be involved in the quality management and improvement activities of the organization.		
	Overall Chapter Compliance Level	SC	
	Subchapter I - Quality Improvement Program: An accreditable organization maintains an active, integrated, organized, and peer-based quality improvement (QI) program as evidenced by the following characteristics:	SC	
A	The organization has a written quality improvement program for ensuring ongoing quality and improving performance when needed. The program is broad in scope in order to address clinical, administrative, and cost-of-care performance issues, as well as actual patient outcomes, i.e., results of care, including safety of patients. At a minimum, the written program:	SC	The center has a written QI program which is reviewed by the Board annually. It also includes peer review, benchmarking, and risk management.
A.1	Addresses the full scope of the organization's health care delivery services and describes how these services are assessed for quality.	SC	
A.2	Identifies the specific committee(s) or individuals responsible for development, implementation and oversight of the program.	SC	The center's director, nursing staff, endoscopy techs, billing manager, and two physicians, one of whom is the Medical Director (Chair), comprise the QI committee, which has oversight of the program.
A.3	Ensures participation by health care professionals, one or more of whom is a physician or dentist. In organizations where a physician or a dentist is not on the medical staff, and the organization is led by an advanced practice registered nurse or a physician assistant, or in a behavioral health setting led by a licensed clinical behavioral health professional, one or more of such licensed healthcare providers is a participant.	SC	

A.4	Includes program purposes, as well as specific objectives that the program intends to achieve.	SC	
A.5	Specifies the data collection processes used to ensure ongoing quality and identify quality-related problems or concerns (see Standard 5.1.B below).	SC	
A.6	Implements activities to improve performance when opportunities for improvement are identified (see Standard 5.1.C below).	SC	
A.7	Describes how the organization integrates quality improvement activities, peer review, and the risk management program.	SC	
A.8	Is evaluated at least annually for effectiveness and to determine if the program's purposes and objectives are continuing to be met.	SC	The governing body reviews the quality program annually.
A.9	Describes processes used to ensure that the results of quality improvement activities, including the annual program evaluation, are reported to the organization's governing body and throughout the organization, as appropriate.	SC	
B	The organization implements data collection processes to ensure ongoing quality and to identify quality-related problems or concerns. Such processes should include but are not limited to:	SC	
B.1	Analysis of the results of peer review activities.	SC	
B.2	Periodic audits of critical processes, as appropriate for the services provided.	SC	
B.3	Ongoing monitoring of important processes and outcomes of care, as appropriate for the services provided (refer to the Glossary in this Handbook for examples).	SC	
B.4	Comparison of the organization's performance to internal and external benchmarks.	SC	
B.5	Methods to systematically collect information from other sources such as, but not limited to, patient satisfaction surveys, financial data, medical/legal issues, and outcomes data.	SC	
B.6	Evaluation of the information and data obtained through the above data collection activities to identify the existence of unacceptable variation or results that require improvement.	SC	
C	The organization demonstrates that ongoing improvement is occurring by conducting quality improvement studies when the data collection processes described in Standard 5.I.B indicate that improvement is or may be warranted. Written descriptions of QI studies document that each study includes the following elements as applicable:	SC	The QI studies reviewed for the survey contained the elements of this Standard.

C.1	A statement of the purpose of the QI study that includes a description of the problemand an explanation of why it is significant to the organization. (See Analyzing Your Quality Management Program and Creating Meaningful Studies in the Worksheets and Forms section in the back of this Handbook.)	SC	
C.2	Identification of the measurable performance goal against which the organization will compare its current performance in the area of study.	SC	
C.3	A description of the data that will be collected in order to determine the organization's current performance (i.e., study methodology).	SC	
C.4	Evidence of data collection.	SC	
C.5	Data analysis that describes findings about the frequency, severity, and source(s) of the problem(s).	SC	
C.6	A comparison of the organization's current performance in the area of study against the previously identified performance goal.	SC	
C.7	Implementation of corrective action(s) to resolve identified problem(s).	SC	
C.8	Re-measurement (a second round of data collection and analysis as described in Standard 5.I.B.4-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.	SC	
C.9	If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued re-measurement until the problem is resolved or is no longer relevant.	SC	
C.10	Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities ("closing the QI loop").	SC	
D	The organization participates in external benchmarking activities that compare key performance measures with other similar organizations, or with recognized best practices of national or professional targets or goals.	SC	External benchmarking compares the center with the other AmSurg centers. Some of the areas benchmarked were burns, falls, infections, hospital transfers, colon perforations, and GIQuIC colonoscopy indicators.
D.1	The organization's benchmarking activities include, but are not limited to:	SC	
D.1.a	The use of selected performance measures that are appropriate for improving the processes or outcomes of care relevant to the patients served.	SC	
D.1.b	Systematically collecting and analyzing data related to the selected performance measures.	SC	

D.1.c	Using benchmarks that are based on valid and reliable local, state, national, or published data.	SC	
D.1.d	Measuring changes in organization's performance on the selected performance measures.	SC	
D.1.e	Demonstrating sustained performance improvement over time.	SC	
D.2	Results of benchmarking activities must be incorporated into other quality improvement activities of the organization.	SC	
D.3	Results of benchmarking activities must be reported to the organization's governing body and throughout the organization, as appropriate.	SC	
	Consultative Comments		Consultative Comments

Chapter 5 - Quality Management and Improvement - Quality Improvement Studies Ia			
Standard		**Compliance Rating**	**Comments**
	Subchapter Ia - Quality Improvement Topics		
	Rating scale for QI studies: **Â Â Â SC = Substantially compliant (meets standards)** **Â Â Â PC = Partially compliant (needs improvement)** **Â Â Â NC = Non-compliant** **Â Â Â N/A = Not applicable** **Â Â Â * = Study ongoing; cannot rate item yet**		
QI1	Quality Improvement Topic #1 (Name of study):	Employee Vaccination Rates	
QI1.1	A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the organization.	SC	To prevent the spread of influenza in the center and comply with CMS requirements for reimbursement.
QI1.2	Identification of the performance goal against which the organization will compare its current performance in the area of study.	SC	The performance goal to reach was 5% greater than the CDC goal of 63.5%. A second goal was to exceed the AmSurg benchmark of 69%.
QI1.3	Description of the data that will be collected in order to determine the organization's current performance.	SC	Data elements collected were:number of Center employees, previous & current year's vaccination rate,reasons cited for declination, and Center's actions to improve participation next year.
QI1.4	Evidence of data collection.	SC	
QI1.5	Data analysis that describes findings about the frequency, severity and source(s) of the problem(s).	SC	
QI1.6	A comparison of the organization's current performance in the area of study against the previously identified performance goal.	SC	For the 2012-2013 flu season, the Center's vaccination rate was at 36%, compared to AmSurg's rate of 72.68%.
QI1.7	Implementation of corrective action(s) to resolve identified problem(s).	SC	For the 2014 flu season, the Center will complete education regarding risks of the flu, and risks associated with the flu vaccine.Free vaccinations or reimbursement for vaccination costs.
QI1.8	Re-measurement (a second round of data collection and analysis as described in Standard 5.II.B-4-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.	SC	The Center improved 9% for a vaccination rate of 45%. But they still did not achieve either goal.
QI1.9	If the initial corrective action(s) did not achieve and/or sustain the desired	*	This is an on-going study with each year, and more corrective actions to be

	improved performance, implementation of additional corrective action(s) and continued remeasurement until the problem is resolved or is no longer relevant.		considered.
QI1.10	Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities ("closing the QI loop").	SC	Dates are documented on the study when it was communicated to the governing board and QAPI Committee.
QI2	Quality Improvement Topic #2 (Name of study):	Medical Supply Costs	
QI2.1	A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the organization.	SC	The Center was budgeted for a $28.00 per procedure supply cost. The Center was trending for a 3 month period at $32.00 supply cost. The purpose is to identify the reason for the cost increase.
QI2.2	Identification of the performance goal against which the organization will compare its current performance in the area of study.	SC	The goal is to reduce supply costs to the budgeted $28.00 amount, before the end of the 4th quarter of 2013.
QI2.3	Description of the data that will be collected in order to determine the organization's current performance.	SC	Medical supply costs were tracked for three months, the summer of 2013. They were evaluated for vendor, quantity, frequency, and pricing.
QI2.4	Evidence of data collection.	SC	
QI2.5	Data analysis that describes findings about the frequency, severity and source(s) of the problem(s).	SC	
QI2.6	A comparison of the organization's current performance in the area of study against the previously identified performance goal.	SC	
QI2.7	Implementation of corrective action(s) to resolve identified problem(s).	SC	The center discovered that automatic deliveries were in place that did not fluxuate with procedure volume. The auto deliveries were stopped, and PAR levels for each supply were established.Also non contracted vendors were utilized at higher prices.The physicians were encouraged not to use supplies from non-contracted vendors.
QI2.8	Re-measurement (a second round of data collection and analysis as described in Standard 5.II.B-4-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.	SC	It was discovered that the automatic orders had not been discontinued and the physicians remained with non-contracted vendors. The cost for supplies per procedure remained at $32.00. They had not met their goal.
QI2.9	If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued remeasurement until the problem is resolved or is no longer relevant.	SC	Due to the implementation of infection control measures, sharp safety measures, and CO2 required monitoring, the goal of $28.00 per procedure was inadequate. The budgeted amount for 2014 was raised to $31.00 per procedure.This was $1.00 under their YTD figure.A re-measurement will take place to see if they have attained that goal.
QI2.10	Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities	SC	

	("closing the QI loop").		
QI3	Quality Improvement Topic #3 (Name of study):	Procedure Cancellation	
QI3.1	A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the organization.	SC	The Center discovered it had a high rate of cancellations, increasing the costs of unused staff.
QI3.2	Identification of the performance goal against which the organization will compare its current performance in the area of study.	SC	The Center would like to achieve a cancellation rate of less than 10% of totaled scheduled cases.
QI3.3	Description of the data that will be collected in order to determine the organization's current performance.	SC	The scheduler was asked to document reasons for cancellations for a two month period.
QI3.4	Evidence of data collection.	SC	
QI3.5	Data analysis that describes findings about the frequency, severity and source(s) of the problem(s).	SC	The data showed the top four reasons for cancellations were: no reason, practice cancelled, deductible or co-pay, and office scheduling error.
QI3.6	A comparison of the organization's current performance in the area of study against the previously identified performance goal.	SC	Out of 622 cases, there were 109 cancellations. This was a cancellation rate of 16%.
QI3.7	Implementation of corrective action(s) to resolve identified problem(s).	SC	A direct fax line was set up to the scheduler's email box, to prevent the faxes from being lost or misplaced.All direct referrals or VA referrals were scheduled within one week of receiving them. Pre-op called the scheduler the day before, to confirm the time and arrival of the patient.
QI3.8	Re-measurement (a second round of data collection and analysis as described in Standard 5.II.B-4-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.	SC	The re-measurement showed the Center still had a cancellation rate of 16%.
QI3.9	If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued remeasurement until the problem is resolved or is no longer relevant.	*	This step is still in progress, with a new goal being set at reducing the cancellation rate by 2%.
QI3.10	Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities ("closing the QI loop").	SC	
QI4	Quality Improvement Topic #4 (Name of study):		
QI4.1	A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the organization.		

QI4.2	Identification of the performance goal against which the organization will compare its current performance in the area of study.		
QI4.3	Description of the data that will be collected in order to determine the organization's current performance.		
QI4.4	Evidence of data collection.		
QI4.5	Data analysis that describes findings about the frequency, severity and source(s) of the problem(s).		
QI4.6	A comparison of the organization's current performance in the area of study against the previously identified performance goal.		
QI4.7	Implementation of corrective action(s) to resolve identified problem(s).		
QI4.8	Re-measurement (a second round of data collection and analysis as described in Standard 5.II.B-4-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.		
QI4.9	If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued remeasurement until the problem is resolved or is no longer relevant.		
QI4.10	Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities ("closing the QI loop").		
QI5	Quality Improvement Topic #5 (Name of study):		
QI5.1	A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the organization.		
QI5.2	Identification of the performance goal against which the organization will compare its current performance in the area of study.		
QI5.3	Description of the data that will be collected in order to determine the organization's current performance.		
QI5.4	Evidence of data collection.		
QI5.5	Data analysis that describes findings about the frequency, severity and source(s) of the problem(s).		
QI5.6	A comparison of the organization's current performance in the area of study		

	against the previously identified performance goal.		
QI5.7	Implementation of corrective action(s) to resolve identified problem(s).		
QI5.8	Re-measurement (a second round of data collection and analysis as described in Standard 5.II.B-4-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.		
QI5.9	If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued remeasurement until the problem is resolved or is no longer relevant.		
QI5.10	Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities ("closing the QI loop").		
ASK.1	In what year did the organization begin to conduct quality improvement studies?	1998	
ASK.2	How many studies has the organization conducted?	13	
ASK.3	This year?	2	
ASK.4	Last year?	2	
ASK.5	Previous year?	3	
ASK.6	How many benchmarking activities have been conducted?	12	
ASK.7	This year?	2	
ASK.8	Last year?	2	
ASK.9	Previous year?	2	
ASK.10	How many studies were reviewed during the survey?	3	
	Consultative Comments		Consultative Comments

Chapter 5 - Quality Management and Improvement - Risk Management II			
Standard		**Compliance Rating**	**Comments**
	Subchapter II - Risk Management: An accreditable organization develops and maintains a program of risk management, appropriate to the organization, designed to protect the life and welfare of an organization's patients and employees. Such an organization has the following characteristics:	SC	
A	The governing body of the organization is responsible for overseeing the program of risk management.	SC	The governing body oversees risk management, which is part of the QAPI program.
B	The governing body designates a person or committee to be responsible for implementation and ongoing management of the risk management program.	SC	The center's internal management, under the direction of the director, directs the risk management program. AmSurg oversees the program with corporate reporting and analysis.
C	Education in risk management activities, and safety policies and processes, is provided to all staff within thirty (30) days of commencement of employment, annually thereafter, and when there is an identified need.	SC	
D	Documented education in infection control policies and processes is provided to all staff within 30 days of commencement of employment, annually thereafter, and when there is an identified need.	SC	
E	Risk management program processes are consistently implemented throughout the organization, including all departments and service locations. These processes address patient safety and other important issues, including but not limited to:	SC	All adverse events are reviewed from a risk perspective.
E.1	A definition of an adverse incident, that includes, at a minimum, the events defined in Standard 5.II.F.	SC	
E.2	The identification, reporting, and analysis of adverse incidents. The analysis identifies the basic or causal factors underlying the incident, and identifies potential improvements in processes or systems, if any exist, to reduce the likelihood of such incidents in the future.	SC	The RL-6 AmSurg incident reporting system is utilized. The adverse event medical record is peer reviewed by the physician peer, the anesthesia peer, and the director completes the RN peer review.
E.3	Encouraging the reporting of near-miss events.	SC	The director initiated the reporting of near-miss events when she started at the center.
E.4	The communication of reportable events as required by law and regulation.	SC	
E.5	Periodic review of all litigation involving the organization and its staff and health care professionals.	SC	

E.6	An ongoing review of patient complaints and grievances which includes defined response times, as required by law and regulation.	SC	Patient complaints, though rare, are reviewed immediately.
E.7	Documentation of timely notification to the professional liability insurance carrier when adverse or reportable events occur.	SC	
E.8	Periodic review of clinical records and clinical record policies.	SC	
F	The organization's Risk Management program includes the definition of an adverse incident that includes, at a minimum:	SC	
F.1	An unexpected occurrence during a health care encounter involving patient death or serious physical or psychological injury or illness, including loss of limb or function, not related to the natural course of the patient's illness or underlying condition	SC	
F.2	Any process variation for which a recurrence carries a significant chance of a serious adverse outcome.	SC	
F.3	Events such as actual breaches in medical care, administrative procedures, or other events resulting in an outcome that is not associated with the standard of care or acceptable risks associated with the provision of care and service for a patient.	SC	
F.4	All events involving reactions to drugs and materials.	SC	
F.5	Circumstances or events that could have resulted in an adverse event (near-miss events).	SC	
G	In addition, the Risk Management policies address:	SC	
G.1	Written methods by which a patient may be dismissed from care or refused care.	SC	
G.2	A process for managing a situation in which a health care professional becomes incapacitated during a medical or surgical procedure.	SC	A policy is in place for the incapacitated health care provider.
G.3	A process for communicating concerns regarding an impaired health care professional.	SC	A policy and process is in place for the impaired health care provider.
G.4	Establishment of responsibility for, and documentation of, coverage after normal working hours.	SC	
G.5	Written policies restricting observers in patient care areas and addressing those persons authorized by the governing body to perform or assist in the procedure area.	SC	

G.6	A requirement for evidence of patient consent for all other persons allowed in patient care areas that are not authorized staff. Examples of unauthorized persons include students, interested physicians, health care industry representatives, surveyors, etc.	SC	
	Consultative Comments		Consultative Comments

Chapter 6 - Clinical Records and Health Information			
Standard		**Compliance Rating**	**Comments**
	An accreditable organization maintains electronic and/or paper clinical records and a health information system from which information can be retrieved promptly. Clinical records are complete, comprehensive, legible, documented accurately in a timely manner, and readily accessible to health care professionals. **The *Clinical Records Worksheet*, found in the *Worksheets and Forms* section of this *Handbook*, may be useful in assessing your organization's compliance with Chapter 6 Standards.**		
	Overall Chapter Compliance Level	SC	
	Number of patient files reviewed during the survey:	10	
	Description of how records were selected:		One transfer medical record and 9 medical records over the last 6 months, evenly divided among the four physicians, were chosen.
A	The organization develops and maintains a system for the proper collection, processing, maintenance, storage, retrieval, and distribution of clinical records.	SC	The center utilizes gastroenterology specific "Provation" software for the physician's procedure note. All other patient records are hard copy and scanned into the medical record.
B	A designated person is in charge of clinical records. This person's responsibilities include, but are not limited to:	SC	The center's director oversees the medical records, and has a signed job description detailing her duties, in her file.
B.1	The confidentiality, security, and physical safety of records.	SC	
B.2	The timely retrieval of individual records upon request.	SC	
B.3	The supervision of the collection, processing, maintenance, storage, and appropriate access to and usage of records	SC	
B.4	Security of the clinical record including:	SC	
B.4.a	A method of tracking who accesses the record in order to block unauthorized access for electronic records.	SC	
B.4.b	A method of identifying designated locations of paper records throughout the organization in order to avoid unauthorized access.	SC	
C	An individual clinical record is established for each person receiving care. Each record includes, but is not limited to:	SC	All identifying criteria are included on the forms, before they are scanned into the medical record, to satisfy this Standard. Provation includes all of the

			following patient information in its software.
C.1	Name	SC	
C.2	Identification number (if appropriate)	SC	
C.3	Date of birth	SC	
C.4	Gender	SC	
C.5	Responsible party, if applicable.	SC	
D	Clinical record entries are legible and easily accessible within the record by the organization's personnel.	SC	
E	If a patient has had three or more visits/admissions, or the clinical record is complex and lengthy, a summary of past and current diagnoses or problems, including past procedures, is documented in the patient's record to facilitate the continuity of care.	SC	Each patient's file had a blank summary form in the chart, and it was completed on the third visit.
F	The presence or absence of allergies and untoward reactions to drugs and materials is recorded in a prominent and consistently defined location in all clinical records. This is verified at each patient encounter and updated whenever new allergies or sensitivities are identified.	SC	A new medication reconciliation form was implemented. The right hand column is where the allergy and reactions were documented on all 10 charts reviewed for the survey.
G	Except when otherwise required by law, the content and format of clinical records, including the sequence of information, are uniform. Records are organized in a consistent manner that facilitates continuity of care.	SC	
H	Documentation regarding missed and canceled appointments is added to the patient's clinical record.	SC	
I	Entries in a patient's clinical record for each visit include, but are not limited to:	SC	All required elements of this Standard are present in the medical record.
I.1	Date (and department, if departmentalized).	SC	
I.2	Chief complaint or purpose of visit.	SC	
I.3	Clinical findings.	SC	
I.4	Studies ordered, such as laboratory or x-ray studies.	SC	
I.5	Care rendered and therapies administered.	SC	
I.6	Any changes in prescription and non-prescription medication with name and dosage, when available.	SC	The director implemented a medication reconciliation form. She thought the nurses understood how to complete them, but when the medical record review

			was completed for the survey, the nurses placed their initials and date by the medications, but still did not add the doses and frequencies. The director had to conduct another in-service to show them that doses and frequencies had to be documented. Credit was given for doses and frequencies on 7/10 charts during the survey, because the physicians had listed them on their current H&P.
I.7	Discharge diagnosis or impression.	SC	
I.8	Disposition, recommendations, and instructions given to the patient.	SC	
I.9	Verification of contents by health care professionals.	SC	
I.10	Signature of, or authentication by, a health care professional on the clinical record entries.	SC	
J	Reports, histories and physicals, progress notes, and other patient information (such as laboratory reports, x-ray readings, operative reports, and consultations) are reviewed and incorporated into the record, as required by the organization's policies.	SC	Refer to Standard 6.I.6 above
K	The date of entry into the clinical record (with or without time of entry) of reports, histories and physicals, progress notes, and other patient information is documented in the patient's record.	SC	
L	Significant medical advice given to a patient by text, email, or by telephone, including medical advice provided after-hours, is permanently entered in the patient's clinical record and appropriately signed or initialed.	SC	
M	Any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of clinical research is clearly contrasted with entries regarding the provision of non-research related care.	SC	
N	Discussions with the patient concerning the necessity, appropriateness, and risks of proposed care, surgery, or procedure, as well as discussions of treatment alternatives, as applicable, are incorporated into the patient's clinical record.	SC	The physician documents that such a discussion took place.
O	The organization ensures continuity of care for its patients. If a patient's primary or specialty care provider(s) or health care organization is elsewhere, the organization ensures that timely summaries or pertinent records necessary for continuity of patient care are:	SC	
O.1	Obtained from the other (external) provider(s) or organization and incorporated into the patient's clinical record.	SC	
O.2	Provided to the other (external) health care professional(s) and, as appropriate, to the organization where future care will be provided.	SC	

P	Except when otherwise required by law, any record that contains clinical, social, financial, or other data on a patient is treated as strictly confidential and is protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure. Patients are given the opportunity to approve or refuse release of records, except when release is permitted or required by law.	SC	
Q	All clinical information relevant to a patient is readily available to authorized personnel any time the organization is open to patients.	SC	
R	Written policies concerning clinical records address, but are not limited to:	SC	
R.1	The retention of active records.	SC	
R.2	The retirement of inactive records.	SC	
R.3	Clear definition for the release and security of information, including accountability for editing, deletion, and access of clinical record content.	SC	
	Consultative Comments		Consultative Comments

Chapter 7 - Infection Prevention, Control, and Safety			
Standard		**Compliance Rating**	**Comments**
	An accreditable organization provides health care services while adhering to safe practices for patients, staff, and all others. The organization maintains ongoing programs designed to (1) prevent and control infections and communicable diseases, and (2) provide a safe and sanitary environment of care.		
	Overall Chapter Compliance Level	SC	
	Subchapter I - Infection Prevention and Control: An accreditable organization maintains an active and ongoing infection prevention and control program as evidenced by the following characteristics:	SC	
A	The organization must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.	SC	
B	The infection prevention and control program includes documentation that the organization has considered, selected, and implemented nationally-recognized infection control guidelines. The program is:	SC	The APIC, ASGE guidelines have been selected for the foundation of the center's infection control program.
B.1	Approved by the governing body.	SC	
B.2	An integral part of the organization's quality improvement program.	SC	
B.3	Under the direction of a designated and qualified health care professional who has training and current competence in infection control.	SC	The center's director, who received training through APIC, oversees the infection control program for the center.
B.4	Appropriate to the organization and meets all applicable state and federal requirements.	SC	
B.5	Responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement	SC	
B.6	Clear to include direct intervention to prevent infection, as needed	SC	
C	The infection control and prevention program reduces the risk of health care-acquired infection as evidenced by education and active surveillance, consistent with:	SC	
C.1	WHO, CDC or other nationally-recognized guidelines for hand hygiene.	SC	APIC guidelines are followed for hand hygiene.

C.2	CDC or other nationally-recognized guidelines for safe injection practices.	SC	
D	Medical staff members, allied health practitioners, employees, volunteers, and others receive infection prevention education and training and comply with requirements.	SC	
E	The organization adheres to professionally accepted standards of practice, manufacturer's recommendations, and state and federal guidelines, including but not limited to the cleaning, disinfection and sterilization of instruments, equipment, supplies, and implants.	SC	The endoscopes are reprocessed per manufacturer's guidelines, using two DSD 201 Medivator re-processors.
F	A written sharps injury prevention program must be present in the organization. Such a program will include:	SC	The center has a sharps program in place and addresses the elements of this Standard.
F.1	Documentation of new employee orientation, annual staff education, and additional education as needed.	SC	
F.2	Disposal of intact needles and syringes into appropriate puncture-resistant sharps containers, in accordance with current state and federal guidelines.	SC	
F.3	Placement of sharps containers in appropriate care areas, secured from tampering.	SC	
F.4	Replacement of sharps containers when the fill line is reached.	SC	No sharps containers were observed to be filled above the fill line.
F.5	Handling, storage, and disposal of filled sharps containers in accordance with applicable regulations.	SC	
G	The organization provides a safe and sanitary environment for treating patients. This includes safeguards to protect the patient from cross-infection through the provision of adequate space, equipment, supplies, and personnel.	SC	
H	Policies are in place for the isolation or immediate transfer of patients with a communicable disease.	SC	
H.1	A mechanism to notify public health authorities of reportable conditions.	SC	
I	Procedures must be available to minimize the sources and transmission of infections, including adequate surveillance techniques.	SC	
J	A written process is in place for the monitoring and documentation of the cleaning, high-level disinfection, and sterilization of medical equipment, accessories, instruments and implants.	SC	Written policies were reviewed during the survey for re-processing the equipment.
K	A written policy addresses the identification and processing of medical equipment and instruments that fail to meet high-level disinfection or sterilization parameters.	SC	

L	Sterile packs of equipment and instruments are handled and stored to maintain sterility.	SC	
M	The organization's written policies address cleaning of patient treatment and care areas which, at a minimum, include:	SC	
M.1	Cleaning before use.	SC	
M.2	Cleaning between patients.	SC	
M.3	Terminal cleaning at the end of day.	SC	
N	Medical devices for use with multiple patients are cleaned and disinfected between patients, following the manufacturer's recommended guidelines or nationally recognized guidelines, whichever are more stringent.	SC	Refer to Standard 7.I.E, above.
	Consultative Comments		Consultative Comments

Chapter 7 - Safety			
Standard		**Compliance Rating**	**Comments**
	Subchapter II - Safety: An accreditable organization adheres to safe practices for patients, staff, and others as evidenced by the following characteristics:	SC	
A	Elements of an organization's written safety program address the organization's environment of care and the safety of patients, staff, and others, and must meet or exceed local, state or federal safety requirements. The elements of the safety program include, but are not limited to:	SC	
A.1	Processes for the management of identified hazards, potential threats, near misses, and other safety concerns.	SC	
A.2	An awareness of, and a process for, the reporting of known adverse incidents to appropriate state and federal agencies when required by law to do so.	SC	
A.3	Processes to reduce and avoid medication errors.	SC	
A.4	Policies addressing manufacturer or regulatory agency recalls related to medications, medical equipment and devices, and food products.	SC	
A.5	Prevention of falls or physical injuries involving patients, staff, and all others. As required by regulation or contract, the reporting of falls or physical injuries is accurate and timely.	SC	
B	There is a person or committee designated by the governing body who is responsible for the organization's safety program.	SC	The center's policies are overseen by the center's director, as the safety officer, which is part of the QI committee and reports to the Board. A signed job description as safety officer was reviewed in her file.
C	Medical staff members, allied health providers, employees, volunteers, and others receive safety program education and training and comply with the requirements.	SC	
D	Unique patient identifiers are consistently used throughout care.	SC	Patients wear arm bands, placed on their arms at registration. They have the information on them to identify each patient.
E	The organization has a comprehensive written emergency and disaster preparedness plan to address internal and external emergencies, including participating in community health emergency or disaster preparedness, when applicable. The written plan must include a provision for the safe evacuation of individuals during an emergency, especially individuals who are at greater risk.	SC	Written emergency and disaster policies and procedures are comprehensive.
F	Personnel trained in cardiopulmonary resuscitation and the uses of cardiac and	SC	All physicians, anesthesia personnel and nurses are certified in advanced

	all other emergency equipment are present in the facility to provide patient care during hours of operation.		cardiac life support.
G	The organization adopts the appropriate policies and procedures to educate medical staff members, employees, volunteers, and other providers and personnel in fire prevention and fire hazard reduction.	SC	
H	Fire safety, fire prevention and fire drills are included in the surveillance activities of personnel responsible for safety and risk management.	SC	Fire drills are conducted quarterly and attendance is recorded.
I	Environmental hazards associated with safety are identified and safe practices are implemented.	SC	
J	Measures are implemented to prevent skin and tissue injury from chemicals, cleaning solutions, and other hazardous exposure.	SC	
K	Evidence of compliance with local, state and federal guidelines is present and adhered to regarding preparing, serving, disposal and storing of food and drink for patient use.	SC	
L	Patients are educated about prescribed medical devices and associated protocols and guidelines. Patient competence with each device is verified before independent use.	SC	
M	Written policies must require documentation of the pre-cleaning, transport, and handling of medical devices intended for external vendor reprocessing, inspection, or repair.	SC	The center had several policies to comply with this Standard. They also have documented a log showing re-processing before sending the scope for repair, and when it returns from repair.
N	Reprocessing of single-use devices must comply with FDA guidelines, and the devices must have been cleared under the FDA 510(k) process.	NA	Single-use devices are not re-processed in this center.
O	The organization has a written policy and process that addresses the recall of items including drugs and vaccines, blood and blood products, medical devices, equipment and supplies, and food products. At a minimum, the policy addresses documentation of:	SC	Policies and processes are in place for recall of medications, medical devices, equipment, and supplies. Blood and blood products are not administered.
O.1	Sources of recall information (FDA, CDC, manufacturers, and other local, state or other federal sources).	SC	
O.2	Methods of notification of staff that need to know.	SC	
O.3	Methods to determine if a recalled product is present at the organization or has been given or administered to patients.	SC	
O.4	Response to recalled products.	SC	
O.5	Disposition or return of recalled items.	SC	

O.6	Patient notification, as appropriate.	SC	
P	Products, including medications, reagents, and solutions, that carry an expiration date are monitored. The organization has a policy for disposal or return of expired medications and supplies that is in accordance with local, state, and federal guidelines.	SC	Processes are in place for checking expired medications, and logs documented that the processes were being completed.
Q	Prior to use, appropriate education is provided to intended operators of newly-acquired devices or products to be used in the care of patients.	SC	
R	The organization has designated a person to be responsible for ensuring that appropriate clinical education occurs prior to allowing the use of a newly-acquired device in the care of a patient. Vendor representatives are not used as the sole source for clinical education.	SC	
	Consultative Comments		Consultative Comments

Chapter 8 - Facilities and Environment			
Standard		Compliance Rating	Comments
	An accreditable organization provides a functionally safe and sanitary environment for its patients, personnel, and visitors.		
	Overall Chapter-Compliance Level	SC	The center is in a 4,329 sq.ft.area, on the third floor of a four story sprinkled facility. It has three procedure rooms, three prep areas, and five post-op bays. It is a very compact center, but organized.
A	The organization provides evidence of compliance with the following:	SC	The facility meets all state and local building and fire codes.
A.1	Applicable state and local building codes and regulations.	SC	
A.2	Applicable state and local fire prevention regulations, such as the NFPA 101Â® Life Safety Code,Â® 2000 Edition, published by the National Fire Protection Association, Inc.	SC	
A.3	Applicable federal regulations.	SC	
A.4	Periodic inspection by the local or state fire control agency, if this service is available in the community.	SC	The fire marshal inspected the center 5/14.
B	The organization ensures that its facilities:	SC	
B.1	Contain fire-fighting equipment to control a limited fire, including appropriately maintained and placed fire extinguishers of the proper type for each potential type of fire.	SC	Fire extinguishers are in place, tagged, dated, and full.
B.2	Have prominently displayed illuminated signs with emergency power capability at all exits, including exits from each floor or hall.	SC	Exit lights and emergency lights are in appropriate locations and tested monthly.
B.3	Have emergency lighting, as appropriate to the facility, to provide adequate illumination for evacuation of patients and staff, in case of an emergency.	SC	
B.4	Have stairwells protected by fire doors, when applicable.	SC	
B.5	Provide reception areas, toilets, and telephones in accordance with patient and visitor volume.	SC	
B.6	Provide examination rooms, dressing rooms, and reception areas that are constructed and maintained in a manner that ensures patient privacy during interviews, examinations, treatment, and consultation.	SC	

B.7	Are operated in a safe and secure manner, with written policy(ies) addressing safety and security practices.	SC	
C	The organization has the necessary personnel, equipment, and procedures to deliver safe care, and to handle medical and other emergencies that may arise.	SC	
D	The organization provides documented periodic instruction of all personnel in the proper use of safety, emergency, and fire-extinguishing equipment.	SC	
E	The organization conducts at least one drill each calendar quarter of the internal emergency and disaster preparedness plan. One of the drills must be a documented cardiopulmonary resuscitation (CPR) technique drill, as appropriate to the organization. The organization must complete a written evaluation of each drill, and promptly implement any needed corrections or modifications to the plan.	SC	The center conducts one code drill per year, (9/14) documents attendance, and writes a review.
F	Smoking is prohibited within the facility.	SC	This is a non-smoking facility and posted as such.
G	Hazards that might lead to slipping, falling, electrical shock, burns, poisoning or other trauma are identified and addressed.	SC	
H	Provisions are made to reasonably accommodate disabled individuals.	SC	
I	Adequate lighting and ventilation are provided in all areas.	SC	
J	Facilities are clean and properly maintained.	SC	
K	A system exists for the proper identification, management, handling, transport, treatment and disposal of hazardous materials and wastes, whether solid, liquid or gas.	SC	
L	The space allocated for a particular function or service is adequate for the activities performed therein.	SC	
M	Appropriate emergency equipment and supplies are maintained and are readily accessible to all areas of each patient care service site.	SC	A crash cart is present and stocked, as well as a defibrillator, which is tested daily.
N	Policies and procedures regarding medical equipment include its standardized use, and documented evidence of periodic testing and scheduled preventive maintenance according to manufacturer's specifications.	SC	Biomedical equipment is professionally inspected semi-annually by Biomedical Services.
O	Testing of fire alarm and inspection of fire suppression systems, including verification of signal transmission, are performed and documented.	SC	The entire building pulls the fire alarms that transmit through to the fire department quarterly. The center participates in those drills, and conducts drills just for the center.
P	When an organization undergoes demolition, construction, or renovation projects, the organization performs a proactive and ongoing risk assessment for	NA	

	existing or potential environmental hazards.		
Q	Ongoing temperature monitoring is performed for items that are frozen, refrigerated and/or heated per product manufacturer's recommendations. Stated temperature ranges are readily available to staff performing the monitoring function. Consultative Comments:	SC	The refrigerator temperature is checked and recorded daily. <u>Consultative Comments</u>

Chapter 9a - Anesthesia Information

Standard		Compliance Rating	Comments
	Chapter 9a - Anesthesia Info		
	If the organization provides any anesthesia services, please select the "X" to mark the appropriate boxes below. If no anesthesia services are provided, leave this page blank.		
	Indicate all levels of anesthesia provided:		
	Local or topical anesthesia - The application of local anesthetic agents, in appropriate doses adjusted for weight.		
	Minimal sedation (anxiolysis) - A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Inhaled nitrous oxide in low concentrations that would not reasonably be expected to result in loss of the patient's life-preserving protective reflexes would be considered minimal sedation.		
	Moderate sedation/analgesia (conscious sedation) - A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.	X	
	Regional anesthesia - The application of anesthetic medication around the nerve or nerves in a major region of the body, which supply the area which is targeted for the abolition of painful neural impulses. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.		
	Deep sedation/analgesia - A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.	X	
	General anesthesia - A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or	X	

	drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.		
	Indicate all health care providers privileged to provide anesthesia:		
	Anesthesiologist		
	Surgeon	X	
	CRNA	X	
	Registered Nurse		
	Anesthesiologist Assistant		
	Others (Please list below):		
	Specify		

Chapter 9 - Anesthesia Services			
Standard		**Compliance Rating**	**Comments**
	Chapter 9 - Anesthesia Services		
	Anesthesia services in an accreditable organization are provided in a safe and sanitary environment by qualified health care professionals who have been granted privileges to provide those services by the governing body.		
	Overall Chapter Compliance Level	SC	
	Was the delivery of sedation or anesthesia observed?	Yes	
	If so, what level?	Deep sedation	
	The sedation/anesthesia was provided by:	CRNA	
	The sedation/anesthesia was supervised by:	Gastroenterologist	
	Standards A through I will be applied at organizations involved in the administration of sedation and anesthesia, including those where only local or topical anesthesia or only minimal sedation is administered.		
A	Anesthesia services provided in the facilities owned or operated by the organization are limited to those techniques that are approved by the governing body upon the recommendation of qualified professional personnel. Anesthesia services are performed only by health care professionals who have been credentialed and granted clinical privileges by the organization in accordance with Chapter 2.II.	SC	CRNAs administer Propofol, as the anesthesia providers, after being privileged and credentialed by the governing body.
B	Adequate supervision of anesthesia services provided by the organization is the responsibility of one or more qualified physicians or dentists who are approved and have privileges for supervision granted by the governing body.[2]	SC	The Gastroenterologist supervises the administration of anesthesia by the CRNA, and they are privileged to do this by the governing body.
C	Policies and procedures are developed for anesthesia services, which include, but are not limited to:	SC	Appropriate anesthesia policies are in place.
C.1	Education, training, and supervision of personnel.	SC	
C.2	Responsibilities of non-physician anesthetists.	SC	
C.3	Responsibilities of supervising physicians and dentists.	SC	

D	A physician, dentist, or qualified health care professional supervised by a physician or dentist, and approved by the governing body, examines the patient immediately prior to administration of the anesthetic to evaluate the risks of anesthesia relative to the procedure to be performed and develops and documents a plan of anesthesia.[2]	SC	The physician and CRNA examine and evaluate the patient prior to anesthesia.
E	The informed consent of the patient or, if applicable, of the patient's representative, is obtained before the procedure is performed. One consent form may be used to satisfy the requirements of this Standard and Standard 10.I.I.	SC	The patient signs two consents, one for the procedure and one for anesthesia.
F	Anesthesia is administered by anesthesiologists, other qualified physicians,dentists, certified registered nurse anesthetists, or other qualified health care professionals approved by the governing body pursuant to Chapter 2.II. Other qualified health care professionals must be directly supervised by a physician or dentist who has been privileged for such supervision.[2]	SC	
G	The facility must be established, constructed, equipped, and operated in accordance with applicable local, state and federal laws and regulations. At a minimum, all settings in which sedation or anesthesia is administered should have the following equipment for resuscitation purposes:	SC	The center has all required equipment for resuscitation.
G.1	Reliable and adequate source of oxygen delivery.	SC	
G.2	A device such as a self-inflating hand resuscitator bag capable of administering at least 90% oxygen.	SC	
G.3	Appropriate emergency drugs, supplies, and equipment.	SC	
G.4	Appropriate monitoring equipment for the intended anesthesia care.	SC	
G.5	Reliable suction source and appropriate equipment to ensure a clear airway.	SC	
H	All clinical support personnel with direct patient contact maintain at a minimum skills in basic cardiac life support (BCLS).	SC	
I	If local or topical anesthesia or minimal sedation is administered, clinical records include entries that, at minimum, address patient evaluation and the administration plan.	SC	Records include documentation of anesthesia.
	Standards A through Z will be applied at organizations that administer moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia, or general anesthesia.		
J	If moderate sedation / analgesia, deep sedation / analgesia, regional anesthesia or general anesthesia is administered, clinical records include entries that, at minimum, address:	SC	Documentation was reviewed in the medical records to satisfy the elements of this Standard.

J.1	Pre-anesthesia evaluation.	SC	
J.2	Intra-anesthesia administration, monitoring, and evaluation.	SC	
J.3	Post-anesthesia recovery evaluation.	SC	
K	A patient's oxygenation, ventilation and circulation must be continually evaluated and documented. Intra-operative physiologic monitoring must include: continuous use of a pulse oximeter; blood pressure determination at frequent intervals, and electrocardiogram (EKG) monitoring for patients during moderate sedation, and for all patients during deep sedation/analgesia or general anesthesia. Monitoring for the presence of exhaled CO2 is required during the administration of deep sedation/analgesia. Monitoring for end tidal CO2 is required during the administration of general anesthesia.	SC	New Mindray monitoring machines were purchased to include all of the above monitoring, including ET CO2, which they did not monitor for the last survey.
L	The organization maintains a written policy with regard to assessment and management of acute pain.	SC	
M	The patient is observed and monitored in a post-anesthesia care unit or in an area that provides equivalent care by methods appropriate to the patient's medical condition and sedation or anesthesia.	SC	
N	A physician or dentist is present until the medical discharge of the patient following clinical recovery from the surgery/procedure and anesthesia.	SC	
O	Before medical discharge from the facility, each patient must be evaluated by a physician, dentist, or delegated, qualified health care professional, supervised by a physician or dentist and approved by the governing body, to assess recovery. If medical discharge criteria have previously been set by the treating physician or dentist, and approved by the governing body, a delegated, qualified health care professional may determine if the patient meets such discharge criteria, and if so, may discharge the patient when those criteria are met.[2]	SC	The time the physician evaluated the patient before discharge was documented on the recovery room nurses' notes.
P	Health care professionals with documentation of current training in advanced cardiac life support (ACLS) are present to provide advanced resuscitative techniques until all patients operated on that day have been physically discharged. When pediatric patients are served, health care professionals with documentation of current training in PALS and age- and size-appropriate resuscitative equipment must be available at all times until pediatric patients operated on that day have been physically discharged. Initial ACLS and PALS training and subsequent retraining shall be obtained from the American Heart Association or another vendor that includes "hands-on" training and skills demonstration of airway management and automated external defibrillator (AED) use.	SC	All of the center's RNs, CRNAs, and physicians are ACLS certified. The director is an ACLS instructor. Pediatric patients are not treated in the center.
Q	Patients who have received moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia or general anesthesia are discharged in the company of a responsible adult.[2]	SC	

R	A safe environment for providing anesthesia services is ensured through the provision of adequate space, equipment, supplies, medications, and appropriately trained personnel. Written policies must be in place for safe use of injectables and single-use syringes and needles. All equipment should be maintained, tested, and inspected according to the manufacturer's specifications. A log is kept of regular preventive maintenance.	SC	
S	Alternate power adequate for the type of surgery/service being performed is available in operative and recovery areas.	SC	The center has alternate power from UPS (uninterrupted power supply) systems. Johnston Technologies services the UPS and completes PMs on it.
T	Education and training in the recognition and treatment of malignant hyperthermia must occur before triggering agents are made available within the organization. Education and malignant hyperthermia drills are conducted at least annually thereafter when triggering agents are present within the organization. Organizations that have anesthetic and resuscitative agents available that are known to trigger malignant hyperthermia must have written protocols to promote patient safety, such as the Malignant Hyperthermia Association of the United States (MHAUS) protocol. (See Appendix D, Malignant Hyperthermia Guidelines.) These treatment protocols must:	NA	No medications which trigger malignant hyperthermia are used in the center.
T.1	Be posted and immediately available in each location where triggering agents might be used.	NA	
T.2	Include the use of dantrolene and other medications, and methods of cooling and monitoring of the patient.	NA	
U	The organization has a written protocol in place for the safe and timely transfer of patients to a predetermined alternate care facility when extended or emergency services are needed to protect the health or well-being of the patient. Standard 4.I addresses medical emergencies that arise in connection with surgical procedures.	SC	
	Standard V will be applied to organizations that provide anesthesia services to children.		
V	If anesthesia services are provided to infants and children, the required equipment, medication, and resuscitative capabilities appropriate to pediatric patients are on site.	NA	Pediatric patients are not treated at the center.
W	No patient shall receive moderate or deep sedation or general anesthesia unless a physician, dentist, or other qualified individual supervised by a physician or dentist, in addition to the one performing the surgery, is present to monitor the patient. The operating physician or dentist may be the supervising physician or dentist. During moderate sedation, the additional individual may assist with minor, interruptible tasks.	SC	
X	Organizations that provide sedative, hypnotic or analgesic drugs that do not have an antagonist medication (for example, propofol) will identify who in the organization, as noted in Standard 9.F, is privileged to administer these drugs.	SC	

Y	In settings where anesthesia may be provided by other than an anesthesiologist, oral and maxillofacial surgeon, certified registered nurse anesthetist, or an anesthesiologist assistant within his/her scope of practice, the organization has a written protocol that explains how the organization will respond in the event that a deeper-than-intended level of sedation occurs.	SC	
	Standards Z through AA will be applied to organizations that administer deep sedation and / or general anesthesia.		
Z	The administration of deep sedation requires monitoring for the presence of exhaled CO2.	SC	Refer to Standard 9.K, above.
AA	The administration of general anesthesia requires:	SC	
AA.1	Monitoring for end-tidal CO2.	SC	Refer to Standard 9.K.
AA.2	A readily available means of measuring body temperature. Consultative Comments	SC	Temperature strips are placed on the foreheads of the patients in prep, and they wear them throughout their stay in the center. **Consultative Comments**
	[2]For organizations that are Medicare-certified or seeking Medicare certification, the Medicare Conditions for Coverage section that begins onpage 69 supersede AAAHC Standards B, D, F, O, and Q.		

Chapter 10 - Surgical and Related Services - General Requirements I			
Standard		**Compliance Rating**	**Comments**
	Chapter 10 - Surgical and Related Services		
	Surgical and related services in an accreditable organization are performed in a safe and sanitary environment by qualified health care professionals who have been granted privileges to perform those procedures by the governing body. The standards in this chapter apply to organizations that provide any invasive procedures, such as pain management, endoscopy procedures, cardiac catheterization, lithotripsy, and in-vitro fertilization, as well as surgery. Such an organization has the following characteristics.		
	Overall Chapter Compliance Level	SC	
	Was a surgical procedure observed during the survey?	Yes	
	Name of procedure:	Esophogastrodu odenoscopy (EGD) with biopsies	
	In this chapter and throughout this *Handbook*, the terms "surgery," "procedure", and "operation" are used interchangeably. The use of any of these terms is to reference any such skill, method, or technique that involves cutting, abrading, suturing, laser or otherwise physically entering or changing body tissues and organs, including invasive pain management procedures. **Note: Some standards may not apply to organizations that only perform minor, superficial procedures without anesthesia or under local or topical anesthesia.**		
	Subchapter I - General Requirements: This subchapter describes general requirements for an organization that provides surgical and related services.	SC	
A	Surgical procedures must be performed in a functional and sanitary environment and are limited to those procedures that are approved by the governing body upon the recommendation of qualified medical staff.	SC	
B	Adequate supervision of surgery conducted by the organization is a responsibility of the governing body. It is recommended that supervision of surgical services be provided by a physician or dentist.	SC	

C	Surgical procedures must be performed in a safe manner only by qualified providers who:	SC	
C.1	Are licensed to perform such procedures within the state in which the organization is located.	SC	The center has been approved for endoscopy procedures by the governing body.
C.2	Have been granted clinical privileges to perform those procedures by the governing body in accordance with Chapter 2.II.	SC	
D	An appropriate and current health history must be completed, with a list of current prescription and non-prescription medications and dosages, when available; physical examination; and pertinent pre-operative diagnostic studies incorporated into the patient's clinical record within thirty (30) days, or according to local, state, or federal requirement, prior to the scheduled surgery/procedure.	SC	A complete history and physical was reviewed on each of the 10 charts for the survey. They included a complete list of medications, doses, and frequency, within the 30 day window.
D.1	The organization has written policies regarding procedures and treatments that are offered to patients, which include criteria for patient selection, the need for anesthesia support, and post-procedural care.	SC	
E	When pre-operative antibiotics are ordered, the use and timeliness of administration is documented in the patient's clinical record.	SC	
F	A written policy is in place for the risk assessment and prevention practices relating to deep vein thrombosis, when appropriate.	SC	The center had this new policy documented.
G	Specific instructions for discontinuation or resumption of medications prior to and after a procedure are provided to the patient with corresponding documentation in the patient's clinical record.	SC	This is documented in the clinical records.
H	The necessity or appropriateness of the proposed surgery, as well as any available alternative treatment techniques, have been discussed with the patient prior to surgery.	SC	
I	The informed consent of the patient or, if applicable, of the patient's representative, is obtained before the procedure is performed.	SC	
J	Registered nurse(s) and other health care professionals assisting in the provision of surgical services are appropriately trained and supervised, and are available in sufficient numbers for the surgical and emergency care provided.	SC	
K	Each operating room is designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and ensures the physical safety of all persons in the area. Only nonflammable agents are present in an operating room, and the room is constructed and equipped in compliance with applicable state and local fire codes.	SC	
L	Health care professionals trained in the use of emergency equipment and BLS must be available whenever there is a patient in the facility. At least one (1)	SC	

	physician or dentist is present or immediately available by telephone whenever patients are physically present in the facility.		
M	With the exception of those tissues exempted by the governing body after medical review, tissues removed during surgery are examined by the pathologist, whose signed report of the examination is made a part of the patient's clinical record.	SC	One chart in the survey chart review had a pathology report, and it was reviewed and signed by the physician.
N	The findings and techniques of a procedure are accurately and completely documented immediately after the procedure by the health care professional who performed the procedure. This description is immediately available for patient care and becomes a part of the patient's clinical record.	SC	Provation software is gastroenterology specific and the physicians document their procedure report into this software, immediately after finishing the procedure.
O	A safe environment for treating surgical patients, including adequate safeguards to protect the patient from cross-infection, is ensured through the provision of adequate space, equipment, supplies, and personnel.	SC	The following elements in this Standard are completed by the center.
O.1	Provisions have been made for the isolation or immediate transfer of patients with a communicable disease.	SC	
O.2	All persons entering operating or procedure rooms are properly attired as defined by the organization's written policy.	SC	
O.3	Acceptable aseptic techniques are used by all persons in the surgical area.	SC	
O.4	A written policy outlines the appropriate and timely surgical hand antisepsis (scrub) using either an antimicrobial soap or an alcohol-based hand rub according to the product manufacturer's recommended guidelines.	SC	
O.5	Only authorized persons are allowed in the surgical or treatment areas, including laser rooms.	SC	
O.6	Environmental controls are implemented to ensure a safe and sanitary environment.	SC	
O.7	Suitable equipment is provided for the regular cleaning of all interior surfaces.	SC	
O.8	Operating/procedure rooms are appropriately cleaned before each procedure.	SC	
O.9	Freshly laundered attire is donned in an area inside of the organization prior to entry into areas designated as restricted.	SC	
O.10	Attire used for personal protective equipment (PPE) or attire contaminated with blood or body fluid is laundered by a laundry that adheres to nationally recognized guidelines and is approved by the organization	SC	
O.11	As needed to minimize the potential contamination of the surgical environment	SC	

	and surgical staff, patient clothing is removed or covered prior to the patient's entry into a surgical area.		
O.12	Measures are implemented to prevent skin and tissue injury from chemicals, cleaning solutions and other hazardous exposure.	SC	
O.13	Fire risks are identified and minimized, and staff members are prepared to address fire hazards, if necessary.	SC	
O.14	Policies are in place for pre-procedure site antisepsis, as appropriate to service(s) provided and patient requirements and needs.	SC	
P	Suitable equipment for immediate use and routine sterilization is available to ensure that operating room materials are sterile. The processes for cleaning and sterilization of supplies and equipment adhere to the manufacturer's instructions and recommendations.	SC	
P.1	Written policies must clearly require documentation of the pre-cleaning, transport, and handling of medical devices intended for external vendor reprocessing, inspection, or repair.	SC	
Q	Sterilized materials are packaged, labeled, and stored in a consistent manner to maintain sterility and identify sterility dates. Internal and external indicators, including biological indicators, are used to demonstrate the safe processing of items undergoing high-level disinfection and sterilization.	SC	
R	Organizations that perform procedures where blood loss and subsequent blood replacement is a potential have policies and procedures to address this type of situation and/or need.	NA	The center does not give blood or blood products.
S	Alternate power adequate for the type of surgery performed is available in operative and recovery areas.	SC	The center utilizes a UPS system for alternate power.
T	Periodic calibration and/or preventive maintenance of equipment is provided.	SC	Biomedical Services is contracted to perform preventative maintenance on patient equipment.
U	The organization utilizes a process to identify or designate the surgical procedure to be performed and the surgical site, and involves the patient in that process. The person performing the procedure marks the site. For dental procedures, the operative tooth may be marked on a radiograph or a dental diagram.	SC	
V	Immediately prior to beginning a procedure, the operating team verifies the patient's identification, intended procedure, and correct surgical site, and that all equipment necessary for performing the scheduled procedure are immediately available in the operating/procedure room. If implantable devices are intended to be used during the procedure, such devices are prepared and made available prior to the start of the procedure and are incorporated into the	SC	The endoscopy tech conducted a very thorough time-out, before the procedure, involving the patient, physician, other tech, and CRNA.

	verification process. The provider performing the procedure is personally responsible for ensuring that all aspects of this verification have been satisfactorily completed immediately prior to beginning the procedure.		
W	The organization identifies the types of procedures requiring counts of sponges, sharps, and instruments.	NA	
W.1	When a count is required, there is a process to ensure that it occurs both before and after the procedure.	NA	
X	A process is in place for the observation, care, and communication of such care in all perioperative areas of the patient's facility experience. The organization must define and implement a process in which information about the patient's care is communicated consistently. The process must include means to educate the staff and medical care providers about the process and support implementation consistently throughout the organization.	SC	
Y	The organization follows established protocols for instructing patients in self-care after surgery, including the provision of written instructions to patients who receive moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia, or general anesthesia.	SC	Patients are given discharge instructions and a copy is in the chart. Anesthesia discharge instructions have now been included, a correction from the previous survey.
Z	Organizations that receive/store/issue blood and blood products for transfusion or human cells or tissues for transplantation must have written protocols for handling, maintenance, and storage, consistent with those of a nationally-recognized authority, such as the American Association of Tissue Banks (AATB) and the U.S. Food and Drug Administration (FDA).	NA	Blood, blood products, and tissue transplantation is not administered in the center.
	Standard AA will be applied to organizations that provide surgical, diagnostic, and/or therapeutic services to children.		
AA	The organization defines pediatric patients, and has policies addressing the care provided and ensuring a safe environment through the provision of adequate space, equipment, supplies, medications, and personnel. Consultative Comments	NA	Pediatric patients are not treated in the center. Consultative Comments
	[4]For more information on the states that have opted out of the requirement for physician supervision of CRNAs, use the following link and scroll down to "Anesthesia Supervision": http://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Spotlight.html		

Chapter 11 - Pharmaceutical Services			
Standard		**Compliance Rating**	**Comments**
	Chapter 11 - Pharmaceutical Services		
	Pharmaceutical services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics. **Note: This chapter applies to any organization that uses drugs or pharmaceutical medical supplies, regardless of the presence or absence of an on-site pharmacy.**		
	Overall Chapter Compliance Level	SC	
A	Pharmaceutical services are provided or made available in a safe and effective manner, in accordance with accepted professional practice and under the direction of an individual designated responsible for pharmaceutical services in accordance with Standard 11.J.	SC	The only pharmaceuticals on site are those used for procedures and post-op. No medications are dispensed and no samples are present.
B	Pharmaceutical services are provided in accordance with ethical and professional practice and applicable federal and state laws.	SC	
C	Staff demonstrates knowledge of applicable state and federal pharmaceutical laws.	SC	
D	Records and security are maintained to ensure the control and safe dispensing of drugs, including samples, in compliance with federal and state laws.	SC	Narcotics are double-locked, logged, and reconciled daily. Propofol is also in a locked cabinet, signing out a supply to each room, then counting it and reconciling it daily.
E	Staff informs patients concerning safe and effective use of medications consistent with legal requirements and patient needs.	SC	
F	Measures have been implemented to ensure that prescription pads are controlled and secured from unauthorized patient access, and pre-signed and/or postdated prescriptions pads are prohibited.	SC	
G	All medications, including vaccines and samples, are checked for expiration dates on a regular basis; expired items are disposed of in a manner that prevents unauthorized access, protects safety, and meets state and federal requirements.	SC	Logs evidence the monthly checks for expiration dates of all medications.
H	All injectable medications drawn into syringes and oral medications removed	SC	While observing the procedure for the survey, the CRNA drew up propofol and

	from the packaging identified by the original manufacturer must be appropriately labeled if not administered immediately.		Xylocaine, and labeled them appropriately.
I	The organization must have policies in place for safe use of injectables and single-use syringes and needles that at minimum include the CDC or comparable guidelines for safe injection practices.	SC	
J	Pharmaceutical services provided by the organization are directed by a licensed pharmacist or, when appropriate, by a physician or dentist who is qualified to assume professional, organizational, and administrative responsibility for the quality of services rendered.	SC	The center contracts with a licensed pharmacist, who is available for questions, or problems, and completes monthly inspections, providing a written report.
K	Providers or other health care professionals who prescribe, dispense, administer, and provide patient education on medications have easy access to current drug information and other decision support resources.	SC	
L	If look-alike or sound-alike medications are present, the organization identifies and maintains a current list of these medications, and actions to prevent errors are evident.	SC	A list of look-alike/sound-alike medications are documented specific for the center. Also, those medications have brightly colored alert labels.
M	Procedures are established by the organization for maintenance, cleaning, distribution and use of devices such as nebulizer units, intravenous infusion pumps, or any other mechanical device used in the medication delivery process.	NA	The center does not have any of these devices.
N	A pharmacy owned or operated by the organization is supervised by a licensed pharmacist.	NA	The center does not own or operate a pharmacy.
O	Pharmaceutical services made available by the organization through a contractual agreement are provided in accordance with the same ethical and professional practices and legal requirements that would be required if such services were provided directly by the organization.	NA	
P	Patients are not required to use a pharmacy owned or operated by the organization. Consultative Comments	NA	 <u>Consultative Comments</u>

Chapter 12 - Pathology and Medical Laboratory Services - CLIA Waived Tests I			
Standard		**Compliance Rating**	**Comments**
	Chapter 12 - Pathology and Medical Laboratory Services		
	Pathology and medical laboratory services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.		
	Overall Chapter Compliance Level	SC	
	Subchapter I - CLIA-Waived Tests: This subchapter applies only to health care organizations providing services that meet the Clinical Laboratory Improvement Amendments (CLIA) of 1988 requirements for waived tests.	SC	The center has a CLIA-waived certificate, ID# 44D0940288, exp.date-02/09/16. The tests they complete under the certificate are urine hcg and blood glucose monitoring.
A	An accreditable organization:	SC	
A.1	Meets the requirements for waived tests under CLIA (part 493 of Title 42 of the Code of Federal Regulations) if it performs its own laboratory services, performs only waived tests, and has obtained a certificate of waiver, and/or	SC	
A.2	Has procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with CLIA if it does not perform its own laboratory services.	SC	The center has a contract and policy in place with Memorial Hospital for laboratory services. The center has the hospital's CLIA certificate on file.
B	Pathology and medical laboratory services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.	SC	
C	Pathology and medical laboratory services include, but are not limited to:	SC	The center contracts with Diagnostic Pathology Services and Miraca. The center has the pathologists' licenses on file. Policies and procedures are in place to address the elements of this Standard.
C.1	Conducting laboratory procedures that are appropriate to the needs of the patients.	SC	
C.2	Performing tests in a timely manner.	SC	
C.3	Distributing test results after completion of a test and maintaining a copy of the results.	SC	
C.4	Performing and documenting appropriate quality control procedures, including,	SC	

	but not limited to, calibrating equipment periodically and validating test results.		
C.5	Ensuring that staff performing tests has adequate training and competence to perform the tests.	SC	
D	The organization has a policy that ensures that test results are reviewed appropriately and that documents that test results are reviewed by the ordering physician or another privileged provider.	SC	The center contracts with two pathology labs. One lab's entire pathology process is electronic; the log, the requests, and the results go directly to the physician, and are reviewed and signed electronically. The other company is all hard copy, logging the requests and specimens out, then logging them when they return, then giving them to the physicians to sign and review, and finally scanning the hard copy into the medical record.
	Consultative Comments		Consultative Comments

Summary Table	Overall Chapter Level
1. Rights of Patients	SC
2. Governance	SC
I. General Requirements	SC
II. Credentialing and Privileging	SC
III. Peer Review	SC
3. Administration	SC
4. Quality of Care Provided	SC
5. Quality Management and Improvement	SC
I. Quality Improvement Program	SC
II. Risk Management	SC
6. Clinical Records and Health Information	SC
7. Infection Prev	SC
I. General Requirements	SC
II. Infection Safety	SC
8. Facilities and Environment	SC
9 - Anesthesia Services	SC
10. Surgical and Related Services	SC
I. Surgical - General	SC
II. Surgical - Laser	NA
III. Surgical - Lithotripsy Services	NA

11. Pharmaceutical Services	SC
12 - Pathology and Medical Lab Services	SC
I. CLIA-Waived Tests	SC
II. CLIA-Laboratories	NA
13. Diagnostic and Other Imaging Services	NA
14. Dental Services	NA
I. Dental Services	NA
II. Dental Home	NA
15 - Other Professional & Technical Services	NA
I. General Services	NA
II. Travel Medicine	NA
16 - Health Education and Health Promotion	NA
17 - Behavioral Health	NA
18. Teaching and Publication Activities	NA
19. Research Activities	NA
20. Overnight Care and Services	NA
21. Occupational Health Services	NA
22. Immediate/Urgent Care Services	NA
23. Emergency Services	NA
24. Radiation Oncology Treatment Services	NA
25. Medical Home	NA

Miscellaneous Information

TRANSFER AGREEMENT

THIS AGREEMENT made effective as September 19, 2011, by and between, The Chattanooga Endoscopy ASC, LLC d/b/a Digestive Disorder Endoscopy Center an outpatient surgery facility duly licensed under the laws of Tennessee with a current provider agreement issued pursuant to Title XVIII and/or Title XIX of the Social Security Act, whose address is 2341 McCallie Avenue, Suite 303 Chattanooga, TN 37404 ("**COMPANY**") and Memorial Health Care System, Inc., a Kentucky nonprofit corporation, d/b/a Memorial Hospital and Memorial North Park Hospital, general acute care hospitals duly licensed under the laws of Tennessee with current provider agreements issued pursuant to Title XVIII of the Social Security Act, whose address is 2525 deSales Avenue, Chattanooga, Tennessee 37404 ("**MEMORIAL**").

WITNESSETH:

WHEREAS, by means of agreement, both COMPANY and MEMORIAL recognize the need to have prearranged transfer agreements such that an individual with a potential emergency condition can be transferred from one facility to the other in the event that the transferring facility does not have the specialized capability required by the individual, or in the event that a facility needs to transfer patients for other reasons, such as an emergency situation in which an evacuation of the facility or of the facility's Emergency Department is necessary; and

WHEREAS, by means of an agreement, both COMPANY and MEMORIAL desire to assist physicians, other care providers and the parties hereto in facilitating timely patient transfers which includes providing available medical records and other information necessary to the further the care and treatment of the patients transferred.

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, and for other valuable consideration the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

1. **Patient Transfer.** COMPANY and MEMORIAL agree to the following provisions related to patient transfers between the parties:

   (a) In the event that one party does not have the specialized capability or capacity required by an individual with an emergency medical condition ("**EMC**") and the other party has the specialized capability and capacity to receive the individual, then the receiving party agrees to accept the transfer of such patient to its facility in order to render stabilizing treatment or other medically appropriate treatment following an appropriate medical screening examination by the transferring facility within its capability.

   (b) In the event that an emergency or public health situation exists whereby one of the parties to this Agreement may need to transfer patients to the other party in order to evacuate the hospital or evacuate the Emergency Department, the receiving facility agrees to accept transfer of such patients.

   (c) In the event that one party does not have the specialized capability to treat a medical condition required by a hospital inpatient and the other party has the specialized capability and capacity to receive the individual, then the receiving party agrees to accept the patient in order to render appropriate medical treatment.

   (d) All transfers between the parties shall be made in accordance with all applicable federal and state laws and regulations, including the Emergency Medical Treatment and Active Labor Act

("EMTALA"), the standards of The Joint Commission ("TJC") and any other applicable accrediting bodies, and reasonable policies and procedures of the parties.

(e) Neither the decision to transfer a patient nor the decision to accept or not to accept a patient transfer shall be predicated upon arbitrary, capricious, or unreasonable discrimination or based upon the patient's ability or inability to pay for services rendered by either party.

(f) The transferring facility's responsibility for patient care shall end and the receiving facility's responsibility for patient care shall begin when the patient arrives on the premises of the receiving facility.

2. **Provision Of Information To Each Party.** COMPANY and MEMORIAL agree:

(a) To provide the other party with the names and/or classifications of persons authorized to initiate, confirm, and accept the transfer of patients on behalf of each party; and

(b) That any transfer procedures shall be made available to the personnel of each of the parties that are involved in patient transfers.

3. **Responsibilities of the Transferring Facility.** The transferring facility shall be responsible for the following:

(a) Providing, within its capabilities, a medical screening examination and stabilizing treatment for any emergency department patient prior to transfer, in accordance with applicable federal and state regulations.

(b) Arranging for appropriate and safe transportation of the patient through the use of qualified personnel and appropriate transportation equipment, including the use of necessary and medically appropriate life support measures during the patient's transfer to the receiving facility, in accordance with applicable federal and state regulations.

(c) Receiving confirmation from the receiving facility that it has the capability and capacity to accept the patient.

(d) Contacting and securing a receiving physician at the receiving facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care prior to patient transfer.

(e) Explaining to the patient prior to transfer the risks and benefits of transfer and obtaining the patient's written consent, or the patient's legal guardian's written consent, prior to transfer. In the event that patient has an EMC, the hospital's obligations under EMTALA must be explained to the patient in addition to the risks and benefits of transfer, in accordance with applicable federal and state regulations.

(f) Obtaining written physician certification that the benefits of patient transfer outweigh the risks of such transfer in cases where the patient being transferred has an EMC, in accordance with applicable federal and state regulations.

(g) Sending a copy of the patient's informed written consent and/or certification required for transfer.

(h) Recognizing the right of a patient to request transfer of his/her care to a physician and/or a facility of the patient's choosing.

(i) Recognizing the right of a patient to refuse to consent to treatment or to transfer and obtaining, or attempting to obtain, an informed refusal of treatment or transfer in writing.

(j) Completing, executing, and sending a copy of the Memorandum of Transfer form to the receiving facility for every patient who is transferred that presented to the transferring facility with an EMC.

(k) Transferring personal effects entrusted to an authorized officer or agent of the transferring facility, particularly money and valuables, and information related to these items. Any personal effects specifically entrusted to an authorized officer or agent of the transferring facility shall be transferred upon signed receipt from a similarly designated individual of the receiving facility.

4. **Responsibilities of the Receiving Facility.** The receiving facility shall be responsible for the following:

(a) Accepting appropriate patient transfers to the facility if the receiving facility has the specialized capabilities not available at the transferring facility and the receiving facility has the capacity to treat the individual.

(b) Accepting appropriate patient transfers to the facility if the receiving facility has the capacity to treat the individual in the event that the transferring facility requires an evacuation of a specific treatment area or of the entire facility.

(c) Cooperating with the transferring facility in coordinating an appropriate patient transfer.

5. **Patient Information and Confidentiality.** The transferring facility will complete and send with each patient at the time of transfer all available medical and demographic information necessary for the receiving facility to provide continuity of care for the patient. The transferring facility will send any additional information that becomes available as necessary for treatment of the patient. Each party agrees to maintain the confidentiality of the medical information so as to comply with all federal and state laws, rules and regulations regarding the confidentiality of patient records.

6. **Payment For Services.** Charges for services performed shall be collected by the party rendering such services directly from the patient, third-party payor or other sources normally billed by the party. The parties to this Agreement shall not have any liability to the other party for such charges. (This provision does not preclude separate written agreements between the parties, for example, the sale, purchase or exchange of supplies or services, or diagnostic or therapeutic services.)

7. **No Payment/Requirement for Referrals.** Nothing in this Agreement shall be construed to require either institution to make referrals of patients to the other institution. No payment shall be made under this Agreement in return for the referral of patients or in return for ordering, purchasing or leasing of products or services.

8. **Independent Contractor.** In performing this Agreement, each party shall be at all times acting as an independent contractor of the other. Neither party shall have, nor exercise or have the right to exercise, any control or direction over the provision of services hereunder by the other party, except as specifically provided herein. Nothing contained in this Agreement shall be construed to create a

partnership or joint venture between the parties, or to authorize either party to act as a general or special agent of the other party, except as specifically set forth herein. The governing body of each party shall have exclusive control of policies, management, assets and affairs of its respective institution. Nothing in this Agreement shall affect or interfere with the rules and regulations of each party as they relate to medical staff membership or privileges of physicians in that facility. The parties shall not assume any liability of the other party by virtue carrying out the terms of this Agreement.

9. **Insurance**. Each party shall, at its sole cost and expense, procure, keep and maintain throughout the term of this Agreement, insurance coverage in the minimum amounts of: One Million Dollars ($1,000,000) per occurrence and One Million Dollars ($1,000,000) annual aggregate for commercial general liability; One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) annual aggregate for professional liability; One Million Dollars each and every occurrence for automobile liability; and applicable state statutory limits for workers compensation. Said coverage may be in form of commercial policies or through a program of self-insurance. In addition to the coverage's specifically listed herein, each party shall maintain any other usual and customary policies of insurance applicable to the work being performed pursuant to this Agreement. Said policy(ies) shall cover all of the parties' services hereunder. By requiring insurance herein, the parties do not represent that coverage and limits will necessarily be adequate to protect the other party, and such coverage and limits shall not be deemed as a limitation on the other party's liability under the indemnities granted to the parties in this Agreement. In the event either party procures a "claims-made" policy to meet the insurance requirements herein, the party agrees to purchase "tail" coverage upon the termination of any such policy or upon termination of this agreement. Said "tail" coverage shall provide for an indefinite reporting period. The parties will obtain all insurance coverage's specified herein from insurers with a current A. M. Bests financial rating of A- or better. In the event that one or more of either party's insurers does not have an A. M. Bests rating, the name of the insurer(s) with appropriate financial information will be forwarded to the other party for review. The use of any insurer that does not have an A. M. Bests rating must be agreed to in advance by the other party. The party will furnish to the other party at least annually or upon renewal, a certificate of insurance evidencing all of the herein specified policies of insurance with an insurer and with limits meeting the requirements of this Agreement. Said policies shall be primary with respect to any insurance maintained by the parties. The parties shall provide copies of any and all insurance policies within ten (10) days of the other party's request for said policies. Failure to maintain the required insurance, as set forth in this Agreement, may result in immediate termination of this Agreement by either party.

10. **Indemnification**. COMPANY agrees to indemnify and hold harmless MEMORIAL, its directors, officers, employees, agents, representatives, successors, assigns, and subcontractors from and against any and all claims, demands, actions, settlements or judgments, including reasonable attorneys' fees and litigation expenses, based upon or arising out of the activities described in this Agreement, where such claims, demands, actions, settlements or judgments relate to the negligence, actions or omissions of COMPANY. MEMORIAL agrees to indemnify and hold harmless COMPANY, its directors, officers, employees, agents, representatives, successors, assigns, and subcontractors from and against any and all claims, demands, actions, settlements or judgments, including reasonable attorneys' fees and litigation expenses, based upon or arising out of the activities described in this Agreement, where such claims, demands, actions, settlements or judgments relate to the negligence, actions or omissions of MEMORIAL. The duties to indemnify and hold harmless shall survive the termination and expiration of this Agreement.

11. **Agreement Not Exclusive**. No part of this Agreement shall be interpreted as limiting the right of either party to make an agreement with any other facility.

12. **Promotional Use/Publicity/Endorsement Authority**. The parties shall not use the existence of this Agreement or the name of either MEMORIAL or COMPANY in connection with any promotional, marketing or advertising material in any medium, including television, radio, written materials including technical or trade publications and journals, electronic, including Internet and intranet, or any other medium, and this Agreement shall not constitute an endorsement by one party of the other party to this Agreement.

13. **Term**. This Agreement shall be in force and effect for an initial term of one (1) year beginning on the Effective Date (the "**Initial Term**"), unless earlier terminated in accordance with its terms. This Agreement shall automatically renew for additional one (1) year terms (each an "**Extended Term**" and together with the Initial Term, the "**Term**") unless otherwise terminated by the parties under the terms of this Agreement.

14. **Termination**.

(a) Automatic Termination. This Agreement shall automatically terminate, without regard to the notice requirements contained in Section fifteen (15), upon the date that either party to this Agreement: (1) ceases to have a valid provider agreement with the Secretary of the Department of Health, Education and Welfare under Title XVIII of the Social Security Act, or subsequent statutory authority amending or replacing said Title; or (2) fails to renew, has suspended, or has revoked its license or registration issued by this State to operate as a health care facility.

(b) Termination With Cause. Either party may terminate this Agreement if the other party has breached a term or condition of this Agreement, provided that the nonbreaching party has given the breaching party written notice of the alleged breach, and the breaching party fails to cure such breach within fifteen (15) calendar days of its receipt of such notice.

(c) Termination Without Cause. Either party may at any time during the term of this Agreement upon thirty (30) days written notice to the other party terminate this Agreement. At the end of the thirty (30) days period, this Agreement shall terminate for all purposes, provided the obligations arising prior to the termination shall be governed by the terms set forth herein until satisfied.

(d) Effect of Termination. Upon Termination of this Agreement pursuant to its terms, the rights and obligations of the parties hereunder shall terminate except as otherwise set forth herein; provided, however, that termination shall not relieve either party of those obligations which by their terms survive termination.

15. **Notice**. Whenever under the terms of this Agreement written notice is required or permitted to be given by any party to any other party, such notice shall be in writing and shall be deemed to have been sufficiently given if personally delivered, delivered by a national overnight courier service (such as Federal Express), transmitted by electronic facsimile or deposited in the United States Mail, in a properly stamped envelope, certified or registered mail, return-receipt-requested, addressed to the party to whom it is to be given, at the address hereinafter set forth. Any party hereto may change its address by written notice in accordance with this Section:

If to MEMORIAL:

Memorial Health Care System
2525 deSales Avenue
Chattanooga, TN 37404
ATTN: James M. Hobson, President & CEO

If to COMPANY: Digestive Disorder Endoscopy Center
2341 McCallie Avenue, Suite 303
Chattanooga, TN 37404
ATTN: Sue Wood, Director

16. **Assignment.** Except as otherwise expressly provided in this Agreement, neither party may assign any of its rights or obligations under this Agreement without the prior written consent of the other party; provided, however, MEMORIAL may assign its rights and duties to an entity that controls, or is controlled by, MEMORIAL or Catholic Health Initiatives.

17. **Excluded Provider.** COMPANY hereby represents and warrants that COMPANY is not and at no time has been excluded from participation in any federally funded health care program, including Medicare and Medicaid. COMPANY hereby agrees to immediately notify MEMORIAL of any threatened, proposed, or actual exclusion of COMPANY from any federally funded health care program, including Medicare and Medicaid. In the event that COMPANY is excluded from participation in any federally funded health care program during the Term of this Agreement, or if at any time after the Effective Date of this Agreement it is determined that COMPANY is in breach of this Section, this Agreement shall, as of the effective date of such exclusion or breach, automatically terminate. COMPANY shall indemnify and hold harmless MEMORIAL against all actions, claims, demands and liabilities, and against all loss, damage, costs and expenses, including reasonable attorneys' fees, arising directly or indirectly, out of any violation of this Section by COMPANY, or due to the exclusion of COMPANY from a federally funded health care program, including but not limited to Medicare or Medicaid, or out of an actual or alleged injury to a person or to property as a result of the negligent or intentional act or omission of COMPANY, or any of COMPANY's employees, subcontractors, or agents providing goods or services in connection with COMPANY's obligations under this Agreement, except to the extent any such loss, damage, costs and expenses were caused by the negligent or intentional act or omission of MEMORIAL, its officers, employees or agents.

18. **Compliance With All Laws, Regulations And Standards.** Each party warrants that all services to be provided hereunder, shall fully comport with all applicable federal, state and local statutes, rules and regulations, and that it shall be deemed a material breach of this Agreement if either party shall fail to observe this requirement.

    1. **HIPAA and HITECH.** Insofar as both parties are Covered Entities as defined by, and are subject to, the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 and implementing regulations ("**HIPAA**"), including the Standards for Privacy of Individually Identifiable Health Information and Security Standards for the Protection of Electronic Health Information at 45 C.F.R. Parts 160 and 164 and by the Health Information Technology for Economic and Clinical Health Act and implementing regulations ("**HITECH**") (collectively "**Privacy and Security Regulations**"), and insofar as each party is granting access to the other of their respective patients' Protected Health Information, and insofar as both parties may be creating, Using and Disclosing Protected Health Information for their respective treatment, payment and operations purposes, as those terms are defined by the Privacy and Security Regulations, both parties warrant and agree to comply with the provisions of the Privacy and Security Regulations.

19. **Jeopardy.** Notwithstanding anything to the contrary herein contained, in the event the performance by either party hereto of any term, covenant, condition or provision of this Agreement jeopardizes the licensure of the other party, its participation in or the payment or reimbursement from Medicare, state sponsored Medicaid program, Blue Cross or other reimbursement or payment programs, or its full

accreditation by The Joint Commission or any other state or nationally recognized accreditation organization, or the tax-exempt status of the other party, any of its property or financing (or the interest income thereon, as applicable), or will prevent or prohibit any physician, or any other health care professionals or their patients from utilizing the other party or any of its services, or if for any other reason said performance should be in violation of any statute, ordinance, or be otherwise deemed illegal, or be deemed unethical by any recognized body, agency, or association in the medical or hospital fields, the other party may at its option (i) terminate this Agreement immediately; or (ii) initiate negotiations to resolve the matter through amendments to this Agreement and if the parties are unable to resolve the matter within thirty (30) days thereafter, the other party may, at its option, terminate this Agreement immediately.

20. **Confidentiality.** COMPANY and MEMORIAL shall hold in confidence the information contained in this Agreement and each party hereby acknowledges and agrees that all information related to this Agreement, not otherwise known to the public, is confidential and proprietary and is not to be disclosed to third persons without the prior written consent of each of the parties except: (i) to the extent necessary to comply with any law, rule or regulation or the valid order of any governmental agency or any court of competent jurisdiction; (ii) as part of its normal reporting or review procedure, to its auditors and attorneys; (iii) to its insurance agent to the extent necessary to obtain appropriate insurance; or (iv) as necessary to enforce its rights and perform its agreements and obligations under this Agreement. COMPANY shall treat all non-public information obtained as part of this engagement as confidential and shall not, without written authorization from MEMORIAL, release or share such information with any third party, except as may be required by law. COMPANY agrees that prior to reporting any actual or perceived violation of law to any governmental entity, even if required by law to do so, it will first discuss any potential legal or compliance matter with MEMORIAL's Corporate Responsibility Officer and MEMORIAL Legal Counsel and, unless otherwise required by law, provide MEMORIAL with an opportunity to investigate and appropriately report any compliance matter brought to its attention by COMPANY.

21. **Recordkeeping.** If and to the extent required by Section 1395x(v)(1)(i) of Title 42 of the United States Code, until the expiration of four (4) years after the termination of this Agreement, COMPANY shall make available, upon written request by the Secretary of the Department of Health and Human Services, or upon request by the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of goods and/or services provided by COMPANY under this Agreement. Although not permitted without MEMORIALS's prior written consent, in the event COMPANY carries out any of its duties under this Agreement through a subcontract with a related organization with a value or cost of Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period, such subcontract shall contain a provision requiring the related organization to make available until the expiration of four (4) years after the furnishing of such services pursuant to such subcontract upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of such subcontract and such books, documents and records of such organization as are necessary to verify the nature and extent of such costs.

22. **Waiver.** No waiver of or failure by any party to enforce any of the provisions, terms, conditions, or obligations herein shall be construed as a waiver of any subsequent breach of such provision, term, condition, or obligation, or of any other provision, term, condition, or obligation hereunder, whether the same or different in nature. No extension of time for performance of any obligations or acts shall be deemed an extension of the time for performance of any other obligations or acts.

23. **Partial Invalidity**. If any provision of this Agreement is found to be invalid or unenforceable by any court or other lawful forum (including an arbiter), such provision shall be ineffective only to the extent that it is in contravention of applicable laws without invalidating the remaining provisions of this Agreement, unless such invalidity or unenforceability would defeat an essential business purpose of this Agreement.

24. **Governing Law**. This Agreement is made and entered into in the State of Tennessee, and shall be governed and construed in accordance with the laws of the State of Tennessee, without reference to the conflicts of law provisions thereof.

25. **Continuing Obligations**. Whether specifically identified or not, the obligations of the parties under this Agreement which by their nature or content would continue beyond the expiration or termination of this Agreement shall survive any expiration or termination of this Agreement.

26. **Amendment**. This Agreement may be amended at any time by mutual agreement of the parties, provided that before any amendment shall become effective, it shall be reduced to writing and signed by each of the parties.

27. **Entire Agreement**. This Agreement constitutes the entire agreement between the parties and contains all of the agreements between them with respect to the subject matter hereof. This Agreement supersedes any and all other agreements, either oral or in writing, between the parties hereto with respect to the subject matter hereof.

28. **No Joint Venture**. It is expressly agreed and understood by the parties hereto that neither party is an agent, partner or joint venturer with or of the other.

29. **Headings**. The headings of the sections of this Agreement are included for the purposes of convenience only and shall not affect the interpretation of any provision hereof.

30. **Expenses**. Except as may be specifically provided for in this Agreement, all parties shall bear their own expenses incurred in connection with this Agreement and the transaction contemplated herein.

31. **Successors and Assigns**. This Agreement shall be binding on COMPANY and MEMORIAL and shall inure to each party's benefit and its respective successors (to the extent specified in any assignment) and permitted assigns.

32. **No Third Party Rights**. This Agreement has been made and is made sole for the benefit of the parties hereto and their respective successors and permitted assigns. Nothing in this Agreement is intended to confer any rights or remedies under or by reason of this Agreement on any persons other than the parties to it and their respective successors and permitted assigns. Nothing in this Agreement is intended to relieve or discharge the obligation or liability of any third persons to any party to this Agreement.

33. **Compliance with CHI Standards of Conduct**. COMPANY recognizes that it is essential to the core values of MEMORIAL that all persons and entities employed by or otherwise contracting with MEMORIAL at all times conduct themselves in compliance with the highest standards of business ethics and integrity and applicable legal requirements, as reflected in the Catholic Health Initiatives Standards of Conduct, as may from time to time be amended by Catholic Health Initiatives. As of the date of this Agreement the Standards of Conduct are set forth in Our Values & Ethics at Work Reference Guide ("**E@W Guide**"), which is available at the following website: http://www.catholichealthinit.org/body.cfm?id=37940. COMPANY acknowledges that COMPANY has

electronically accessed, obtained or otherwise received a copy of the E@W Guide and agrees to act in a manner consistent with, and at all times abide by, such Standards of Conduct, to the extent the same are applicable to COMPANY in the performance of this Agreement. In the event that MEMORIAL determines in good faith that COMPANY has breached its obligations pursuant to this Section, MEMORIAL may immediately terminate this Agreement without penalty.

34. **Ethical and Religious Directives**. COMPANY agrees that all services to be furnished by COMPANY hereunder shall be performed in accordance with the Ethical and Religious Directives for Catholic Health Care Services, Fourth Edition, as promulgated by the United States Conference of Catholic Bishops as amended from time to time, and as interpreted by the local bishop. The Ethical & Religious Directives are available at the following website: http://www.usccb.org/about/doctrine/ethical-and-religious-directives/.

IN WITNESS WHEREOF, we, the undersigned, duly authorize representatives of the parties to this Agreement herein above expressed, have entered into this Agreement without reservation and have read the terms herein.

MEMORIAL HEALTH CARE SYSTEM

By: _____

Title: President & CEO

Date: 9-29-11

THE CHATTANOOGA ENDOSCOPY ASC, LLC
d/b/a Digestive Disorder Endoscopy Center

By: Susan Wood

Title: Center Director

Date: 9/13/11

FACILITY TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (the "Agreement") is made as of this 1st day of April, 2015, by and between Parkridge Medical Center, Inc., doing business as Parkridge Medical Center, Parkridge East Hospital, Parkridge Valley, and Parkridge West and Digestive Disorders Endoscopy Center, each individually referred to herein as "facility," or "Transferring Facility" if transferring a patient, or "Receiving Facility" if receiving a patient, pursuant to the terms and provisions of the Agreement, and collectively as "facilities."

WITNESSETH:

WHEREAS, the parties hereto desire to enter into the Agreement governing the transfer of patients between the two facilities; and,

WHEREAS, the parties hereto desire to enter into the Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities;

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties hereto agree as follows:

1. **TRANSFER OF PATIENTS.** In the event any patient of either facility is deemed by that facility (the "Transferring Facility") as requiring the services of the other facility (the "Receiving Facility") and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department of the Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of the Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO") and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious, or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. **RESPONSIBILITIES OF THE TRANSFERRING FACILITY.** The Transferring Facility shall be responsible for performing or ensuring performance of the following:

   (A) Provide, within its capabilities, for the medical screening and stabilizing treatment of the patient prior to transfer;

   (B) Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations;

   (C) Designate a person who has authority to represent the Transferring Facility and coordinate the transfer of the patient from the facility;

   (D) Notify the Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient;

   (E) Prior to patient transfer, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care;

   (F) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient;

(G) Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician;

(H) Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and with respect to a patient with an emergency medical condition that has not been stabilized, a copy of the patient's informed consent to the transfer or physician certification that the medical benefits of the transfer outweigh the risk of transfer. If all necessary and relevant medical records are not available at the time the patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible;

(I) Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items;

(J) Notify the Receiving Facility of the estimated time of arrival of the patient;

(K) Provide for the completion of a certification statement, summarizing the risk and benefits of the transfer of a patient with an emergency condition that has not been stabilized, by the transferring physician or other qualified personnel if the physician is not physically present at the facility at the time of transfer;

(L) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

(M) Recognize the right of a patient to request to transfer into the care of a physician and facility of the patient's choosing;

(N) Recognize the right of a patient to refuse consent to treatment or transfer;

(O) Complete, execute, and forward a memorandum of transfer form to the Receiving Facility for every patient who is transferred;

(P) Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to the Receiving Facility; and,

(Q) Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

3. **Responsibilities of the Receiving Facility.** The Receiving Facility shall be responsible for performing or ensuring performance of the following:

(A) Provide, as promptly as possible, confirmation to the Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond to the Transferring Facility within thirty (30) minutes after receipt of the request to transfer a patient with an emergency medical condition or in active labor;

(B) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred, maintain a call roster of physicians at the Receiving Facility and provide, on request, the names of on-call physicians to the Transferring Facility;

(C) Reserve beds, facilities, and services as appropriate for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician unless such are needed by the Receiving Facility for an emergency;

(D) Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility;

(E) When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician;

(F) Provide the Transferring Facility with a copy of the patient's clinical or medical records, including any record generated in the emergency department;

(G) Maintain the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law;

(H) Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into the facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient;

(I) Provide for the return transfer of patients to the Transferring Facility when requested by the patient or the Transferring Facility and ordered by the patient's attending/transferring physician, if the Transferring Facility has a statutory or regulatory obligation to provide health care assistance to the patient, and if transferred back to the Transferring Facility, provide the items and services specified in Section 2 of the Agreement;

(J) Provide the Transferring Facility any information available about the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;

(K) Upon request, provide current information concerning its eligibility standards and payment practices to the Transferring Facility and patient;

(L) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provided;

(M) Complete, execute, and return the memorandum of transfer form to the Transferring Facility; and,

(N) Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

4. **BILLING.** All claims or charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to the Agreement shall be billed and collected by the facility providing such services directly from the patient, third party payer, Medicare or Medicaid, or other sources appropriately billed by that facility, unless applicable law and regulations require that one facility bill the other facility for such services. *In those cases in which the regulations apply, the facilities shall bill in accordance to the regulations that apply to skilled nursing facility prospective payment system ("SNF PPS") and consolidated billing. In those cases in which payment rates are consistent with SNF PPS regulations and have been negotiated, such payment shall be made at N/A % of charges or in accordance with the payment fee schedule, labeled as Exhibit N/A, attached hereto and incorporated herein by this reference.* The parties agree to comply with the provisions set forth immediately below in the event that the patient is a Medicare beneficiary and a patient if a skilled nursing facility ("SNF") or a long term care facility ("LTCH"). In addition, it is understood that professional fees will be billed by those physicians or other professional providers who actually participate in the care and treatment of the patient and who are entitled to bill for their professional services at usual and customary rates. Each facility agrees to provide

information in its possession to the other facility and such physicians or professional providers sufficient to enable them to bill the patient, responsible party, or appropriate third party payer.

5. **TRANSFER BACK; DISCHARGE; POLICIES.** At such time as the patient is ready for transfer back to the Transferring Facility or another health care facility or discharge from the Receiving Facility, in accordance with the direction from the Transferring Facility and with the proper notification of the patient's family or guardian, the patient will be transferred to the agreed upon location. If the patient is to be transferred back to the Transferring Facility, the Receiving Facility will be responsible for the care of the patient up until the time the patient is re-admitted to the Transferring Facility.

6. **COMPLIANCE WITH LAW.** Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of clinical or medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

7. **INDEMNIFICATION; INSURANCE.** The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents, and shall indemnify and hold harmless the other party from and against any and all claims, liabilities, causes of action, losses, costs, damages and expenses (including reasonable attorney's fees) incurred by the other party as a result of such acts and omissions. In addition, each party shall maintain, throughout the term of the Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts reasonably acceptable to the other party, and shall provide evidence of such coverage upon request.

8. **TERM; TERMINATION.** The term of the Agreement shall be three (3) years, commencing on the 1st day of April, 2015, and ending on the 31st day of March, 2018, unless sooner terminated as provided herein. Either party may terminate the Agreement without cause upon thirty (30) days advance written notice to the other party. Either party may terminate the Agreement upon breach by the other party of any material provision of the Agreement, provided such breach continues for five (5) days after receipt by the breaching party of written notice of such breach from the non-breaching party. The Agreement may be terminated immediately upon the occurrence of any of the following events:

   (A) Either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately, or

   (B) Either facility loses its license, or Medicare certification.

   The Agreement may be renewed for subsequent one (1) year terms upon the mutual written consent of the parties.

9. **ARBITRATION.** Any dispute or controversy arising under, out of or in connection with, or in relation to the Agreement, or any amendment hereof, or the breach hereof shall be determined and settled by arbitration in Chattanooga, Tennessee, in accordance with the rules of the American Health Lawyers Association Alternative Dispute Resolution Services and applying the laws of the stated specified in section 11 below. Any award rendered by the arbitrator shall be final and binding upon each of the parties, and judgment thereof may be entered in any court having jurisdiction thereof. The costs shall be borne equally by both parties. Pending any such arbitration and until final judgment thereon has been entered, the Agreement shall remain in full force and effect unless otherwise terminated provided hereunder.

10. **ENTIRE AGREEMENT; MODIFICATION.** The Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. The Agreement may not be amended or modified except by mutual written agreement.

11. **GOVERNING LAW.** The Agreement shall be construed in accordance with the laws of the State of Tennessee.

12. **PARTIAL INVALIDITY.** If any provision of the Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of the Agreement.

13. **NOTICES.** All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to: Darrell Moore, President/CEO
2333 McCallie Avenue
Chattanooga, TN 37404
Attention: Chief Executive Officer

Copy to: Legal Department
One Park Plaza, P.O. Box 550
Nashville, TN 37202-0550

If to: Digestive Disorders Endoscopy Center
ATTN: Sue Wood, Center Director
2341 McCallie Avenue, Plaza 3
Chattanooga, TN 37404
Attention: Chief Executive Officer

or to such other persons or places as either party may from time to time designate by written notice to the other.

14. **WAIVER.** A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

15. **ASSIGNMENT; BINDING EFFECT.** Facilities shall not assign or transfer, in whole or in part, the Agreement or any of Facilities' rights, duties or obligations under the Agreement without the prior written consent of the other Facility, and any assignment or transfer by either Facility without such consent shall be null and void. The Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

16. **CHANGE IN LAW.** Notwithstanding any other provision of the Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payer, or any other federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation, or if any court of competent jurisdiction renders any decision or issues any order, at any time while the Agreement is in effect, which prohibits, restricts, limits or in any way substantially changes the method or amount of reimbursement or payment for services rendered under the Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend the Agreement to the satisfaction of both parties, to compensate for such prohibition, restriction, limitation or change. If the Agreement is not so amended in writing within three (3) days after said notice was given, the Agreement shall terminate as of midnight on the third (3rd) day after said notice was given.

17. **WARRANTY OF NON-EXCLUSION.** Each party represents and warrants to the other that the party, its officers, directors and employees (i) are not currently excluded, debarred, or otherwise ineligible to participate in the federal health care programs as defined in 42 U.S.C. §1320a-7b(f) (the "federal healthcare programs"), (ii) have not been convicted of a criminal offense related to the provision of healthcare items or services but have not yet been excluded, debarred, or otherwise declared ineligible to participate in the federal healthcare programs, and (iii) are not, to the best of its knowledge, under investigation or otherwise aware of any circumstances which may result in the party or any such individual being excluded from participation in the federal healthcare programs. This shall be an ongoing representation and warranty during the term of the Agreement and each party shall immediately notify the other of any change in the

status of the representations and warranty set forth in this section. Any breach of this section shall give the other party the right to terminate the Agreement immediately for cause.

18. **HIPAA COMPLIANCE REQUIREMENTS.** Each party agrees to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. §1320d ("HIPAA") and any current and future regulations promulgated thereunder including without limitation the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Part 142 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162, all collectively referred to herein as "HIPAA Requirements," to the extent applicable. Each party agrees not to use or further disclose any Protected Health Information (as defined in 45 C.F.R. §164.501) or Individually Identifiable Health Information (as defined in 42 U.S.C. §1320d), other than as permitted by HIPAA Requirements and the terms of the Agreement. To the extent applicable under HIPAA, each party shall make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services to the extent required for determining compliance with the Federal Privacy Regulations.

19. **ACCESS TO RECORDS.** Pursuant to the requirements of 42 CFR §420.300 et seq., each party agrees to make available to the Secretary of Health and Human Services ("HHS"), the Comptroller General of the Government Accounting Office ("GAO") or their authorized representatives, all contracts, books, documents and records relating to the nature and extent of costs hereunder for a period of four (4) years after the furnishing of Services hereunder for any and all Services furnished under the Agreement. In addition, each party hereby agrees to require by contract that each subcontractor makes available to the HHS and GAO, or their authorized representative, all contracts, books, documents and records relating to the nature and extent of the costs thereunder for a period of four (4) years after the furnishing of Services thereunder.

20. **EXECUTION OF AGREEMENT.** The Agreement shall not become effective or in force until all of the below named parties have fully executed the Agreement.

IN WITNESS WHEREOF, the parties hereto have executed the Agreement as of the day and year first above written.

Parkridge Medical Center, Inc.

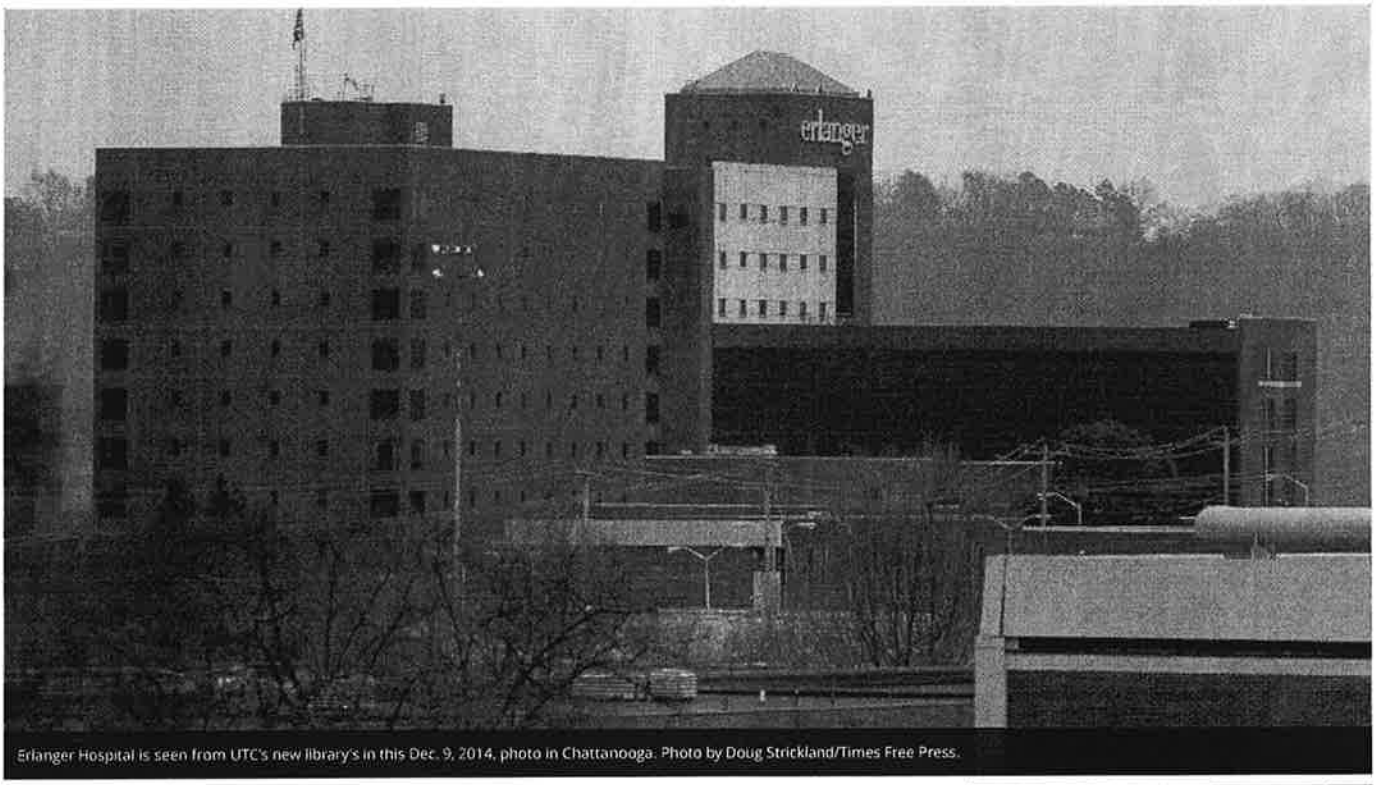
By: _____
Its: Darrell Moore, President/CEO

Digestive Disorders Endoscopy Center

By: _____
Its: Chief Executive Officer

Hutcheson Medical Center, Walker County called 'increasingly desperate'

April 23rd, 2015 | by Tyler Jett | in Local Regional News | Read Time: 4 mins.



Erlanger Hospital is seen from UTC's new library's in this Dec. 9, 2014, photo in Chattanooga. Photo by Doug Strickland/Times Free Press.

TIMELINE OF EVENTS

* **2009-10:** Hutcheson Medical Center loses about $14 million
* **May 2011:** Losing about $1 million a month, Hutcheson officials and Erlanger Health System officials enter into a management agreement
* **June 2013:** Hutcheson posts a profit and announces it will enter a leasing agreement with Erlanger for 10 years. But the agreement falls apart after a study of Hutcheson's financial viability and market share value.
* **August 2013:** Hutcheson severs the management agreement, claiming Erlanger did not hold up its end of the pact.
* **September 2013:** Hutcheson seeks other health care providers to take over management. Only Erlanger and Chattanooga company Lincoln Healthcare submit proposals, and Hutcheson accepts neither.
* **January 2014:** Erlanger sues Hutcheson,

With an uppercut, Erlanger Health System responded to fraud accusations this week, saying leaders from Hutcheson Medical Center and Walker County, Ga., are liars.

Erlanger and Hutcheson are tangled in federal lawsuits with millions at stake -- half of which might come from the pockets of Walker County taxpayers. Three weeks ago, Hutcheson's attorneys said Erlanger secretly received emails it should not have seen, giving its leaders a competitive edge against the Fort Oglethorpe hospital.

On Monday, Erlanger's lawyer called that accusation nonsense.

"[Hutcheson's] penchant for hyperbole and unfounded accusations against Erlanger is nothing new," attorney Edward Marshall wrote in a U.S. District Court filing. "Desperate circumstances, and a desire to escape from a $20 million debt without paying a cent, have caused HMC and Walker County to do increasingly desperate things.

"But HMC's most recent filing ... takes those acts of desperation from the frustrating to the truly offensive."

Hutcheson CEO Farrell Hayes stands by his attorneys' claim from earlier this month.

demanding loan repayment.

*** February 2014:** Hutcheson countersues. Its attorney, former Georgia Gov. Roy Barnes, claims Erlanger did not hold up its end of the management agreement.

* July 2014 Erlanger moves to foreclose and auction the hospital's property.

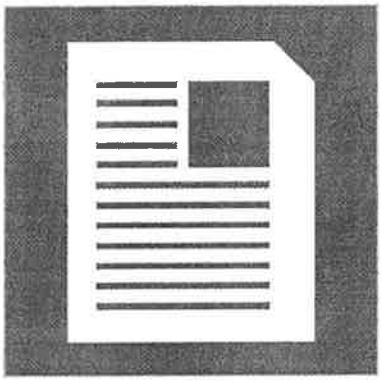
*** August 2014:** A federal judge in Rome, Ga., halts the planned foreclosure, saying that keeping the hospital open is in the public interest and overcoming an auction sale could be "insurmountable" for the hospital.

* November 2014: Hutcheson files for Chapter 11 bankruptcy.

*** April 3, 2015:** Hutcheson's attorneys accuse Erlanger of fraud, say Erlanger got secret emails during 2011 negotiations.

*** April 20, 2015:** Erlanger says the emails were not secret.

Document: Don Oliver letter to Hutcheson board members



Don Oliver writes to Hutcheson board members urging them to reflect on the seriousness of the situation in which the hospital finds itself.

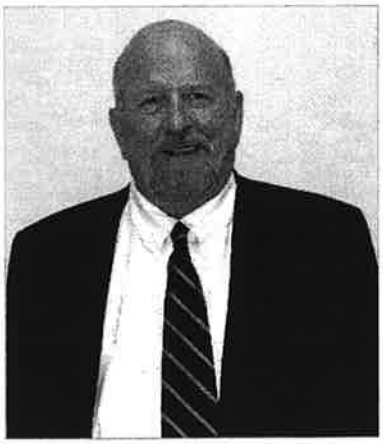


Photo by Contributed Photo/Times Free Press.

"We obviously disagree with Erlanger's position and we will be filing a reply with the Court," he wrote in an email Wednesday. "We respect [U.S. District Court Judge Harold] Murphy's ability to decide these issues on their merits and to see beyond the rhetoric in Erlanger's filings."

Walker County Commissioner Bebe Heiskell, meanwhile, said she didn't understand why Erlanger called her a liar, too: "I haven't opened my mouth. So they're not talking about me."

In 2011, when Hutcheson was losing $1 million a month, it entered into a management agreement that contracted Erlanger to manage the North Georgia hospital.

As part of the deal, Erlanger officials gave Hutcheson a $20 million loan. Catoosa and Walker county commissioners agreed to pay that money back if Hutcheson couldn't.

In August 2013, the two hospitals broke up. Erlanger sued Hutcheson to get the $20 million. In turn, Hutcheson sued Erlanger, claiming hospital officials from Chattanooga didn't give Hutcheson the help they promised.

On April 3, Hutcheson's lawyers accused Erlanger of fraud in a court filing. Hutcheson officials said their former lawyer, Ward Nelson, secretly gave emails to Erlanger's leaders in 2011, when the two hospitals negotiated the management agreement.

In the filing, Hutcheson's new lawyer asked Murphy to make Erlanger give the Fort Oglethorpe hospital at least $60 million in damages.

On Monday, Erlanger's lawyers said in a court filing that their opponent's argument is based on a lie.

Yes, Nelson gave Erlanger officials emails to and from Hutcheson's leaders. But, Erlanger said, those emails were not protected by attorney-client privilege. They only contained public information about Hutcheson's desperation for money.

Of the emails in question, Nelson and Hutcheson exchanged the first one on Feb. 23, 2011. At that point, Erlanger officials were already watching Hutcheson's ship begin to sink. Bill Cohen, a board member of the hospital authority that governs Hutcheson, told the Times Free Press in January 2011, "Probably half the people in three counties know we're broke."

Two weeks later, Hutcheson Chief of Staff Dr. Steve Perlaky told the newspaper, "The only way to survive is to merge services with Erlanger."

And even if that information wasn't public knowledge, Erlanger's lawyers wrote in Monday's court filing, the emails between Hutcheson and Nelson still weren't protected by attorney-client privilege because other people besides Erlanger officials read the messages.

The Catoosa and Walker county commissioners and lawyers also saw the emails. Earlier this month, Hutcheson argued that the local government officials could read the messages, too, because in 2011 they were on the same team as Hutcheson.

Erlanger attorney Jeff Woodard said that's not true. During the six months when the hospitals negotiated a management agreement, he said in a court filing, Walker County Attorney Don Oliver upset officials from Catoosa County, Hutcheson and Erlanger, "jeopardizing HMC's chances to

survive."

In March 2011, Woodard said, Walker County rejected a management agreement between the hospitals, demanding that new attorneys examine it.

Even inside Hutcheson, court filings show, members of the hospital authority argued with another one of the hospital's boards, one of many governing bodies inside Hutcheson's tangled web of power. The hospital authority had actually created that board in 1995, something Oliver said its members must now regret.

"Like a terminator robot from a modern horror movie," Oliver wrote in an email to the hospital authority in March 2011, "it has taken a life of its own; it is literally trying to stamp out and eliminate its creator."

Oliver, who also compared Erlanger and Hutcheson to "Keystone Cops" in the email, did not return a call seeking comment.

Contact staff writer Tyler Jett at tjett@timesfreepress.com or at 423-757-6476.

http://www.timesfreepress.com/news/business/aroundregion/story/2014/jul/31/unhealthy-fight-hutcheson-hospital-faces/263229/

Hutcheson hospital faces foreclosure as Erlanger moves to collect unpaid debt

Times Free Press, Article by David Flessner, July 31, 2014

Three years after Erlanger Health System promised to revive Hutcheson Medical Center with a $20 million loan and new management, Chattanooga's biggest hospital has severed its management and talks with Hutcheson and plans to foreclose on the Fort Oglethorpe hospital on Tuesday to try to recover its unpaid debt.

But Hutcheson and its senior lender, Regions Bank, claim such a sale of a public hospital is not allowed in Georgia and will ask a federal judge in Rome, Ga., on Friday to stop the planned sale of Hutcheson assets.

Farrell Hayes, the president of Hutcheson who took over management of the hospital from Erlanger last November, said he had hoped to arrange a plan to repay the Erlanger debt along with other hospital obligations. But talks with Erlanger officials stopped a month ago when Erlanger initiated a foreclosure action against Hutcheson.

"Hutcheson belongs to the citizens of Walker, Catoosa and Dade counties, and we cannot understand why a big Chattanooga hospital would go to such lengths to try and put a community hospital out of business," Hayes said. "But until and unless there is a court order to the contrary, Hutcheson will continue to do what it has done for the past 62 years, which is to provide quality, local health care to the citizens of Northwest Georgia."

Hayes said he still sees a need for a hospital to serve Northwest Georgia and is even eager to restore services such as labor and delivery that Hutcheson had to cut out due to its recent operating losses.

But Erlanger contends that Hutcheson, which terminated its management agreement with Erlanger last year, still owes more than $20 million to Erlanger and may no longer be viable as a free-standing hospital.

Representatives of the two public hospitals met and tried to negotiate a repayment plan during June, but talks broke off earlier this month.

The three counties that own the hospital and secured the debt declined an Erlanger offer last month to waive a foreclosure requirement for debt recovery, Erlanger attorney Karen Bragman said in a 26-page court filing this week.

"Erlanger made plain it had no burning inclination to proceed with foreclosure," Bragman said. "Unfortunately, neither the counties nor (Hutcheson hospital) have signaled an inclination to accept Erlanger's offer."

Hayes said he still hopes there can be a negotiated settlement to avoid a

costly and image-damaging foreclosure and legal fight over the hospital.

But Erlanger spokesman Pat Charles said Erlanger has tried to keep the hospital operating while the debt is repaid without success and Erlanger's last offer to Hutcheson was rejected.

"Despite protracted, vigorous efforts, the debtor and its guarantors were never able to make any settlement offer that would have provided Erlanger with any material or timely repayment of its indebtedness," she said. "Based on this history, Erlanger is not optimistic about the chance of settlement."

Hutcheson has struggled to pay its debts in recent years as physicians and patients have shifted to other hospitals. Hutcheson sold its majority interest in Battlefield Imaging for $5.2 million in early July to help the hospital refinance its debt and pay its employees and debtors, including a $650,000 line of credit previously provided by Walker County.

But Hutcheson remains $60 million in debt, including more than $20 million still owed to Erlanger for a 2011 loan that was supposed to recapitalize and strengthen Hutcheson.

Former Georgia Gov. Roy Barnes, an attorney hired by Hutcheson, claims that it is Erlanger that owes money to Hutcheson because Erlanger did more to damage the Fort Oglethorpe hospital during its management tenure than it lent or helped the hospital. Barnes claims Erlanger mismanaged Hutcheson to boost its own hospital business.

"In just over 18 months, with Erlanger and its leadership fully in charge of all Hutcheson's operations and expenditures, Erlanger exhausted the entire $20 million line of credit (plus another $550,000 promissory note executed on May 3, 2013 to pay staff) while refusing to properly staff Hutcheson with physicians and executive officers and generally taking this opportunity to funnel potentially profitable patients across state lines to its own hospital back in Chattanooga," Barnes said in a legal filing last week.

The foreclosure, if it occurs, doesn't mean that Hutcheson hospital would shut down. The purchaser at any foreclosure sale would likely want to keep the hospital running to maintain a revenue stream and the value of the property, although a new owner could sell off some equipment or try to change the way the hospital operates.

But Erlanger's chief administrative officer, Gregg Gentry, said in a court hearing that he doesn't think the Fort Oglethorpe hospital can continue to operate for much longer.

"Erlanger has worked diligently to keep Hutcheson open, but genuinely believes that there is little chance for the hospital to survive," Gentry said.

Beyond the initial $20 million loan, Erlanger lent another $550,000 last year to help the hospital meet its payroll and Regions Bank also loaned millions of dollars over and above the bond financing to keep Hutcheson operating,

Gentry said.

Walker, Catoosa and Dade counties are financially obligated to repay Erlanger for the $20 million loan even if the hospital fails, Gentry said. The intergovernmental agreement that provided the loans to Hutcheson includes provisions that property taxes would have to be raised, if necessary, to repay the Erlanger loan.

Beyond the financial bleeding at Hutcheson, the hospital's unpaid debts are also hurting the fiscal health of the three counties that own the public hospital.

The bond rating agency Standard and Poor's recently downgraded Walker County's general obligation bonds by four notches to BBB-plus "based on the county's weak liquidity stemming from the loans it guarantees that are subject to immediate acceleration (at Hutcheson hospital)."

The lower bond rating means Walker County will have to pay a higher rate of interest when it goes to the bond market for future borrowings.

Contact Dave Flessner at dflessner@timesfreepress.com or at 757-6340.

Hamilton County, Tennessee

People QuickFacts	Hamilton County	Tennessee
Population, 2014 estimate	351,220	6,549,352
Population, 2013 estimate	349,030	6,497,269
Population, 2010 (April 1) estimates base	336,465	6,346,275
Population, percent change - April 1, 2010 to July 1, 2014	4.4%	3.2%
Population, percent change - April 1, 2010 to July 1, 2013	3.7%	2.4%
Population, 2010	336,463	6,346,105
Persons under 5 years, percent, 2013	5.9%	6.2%
Persons under 18 years, percent, 2013	21.3%	23.0%
Persons 65 years and over, percent, 2013	15.6%	14.7%
Female persons, percent, 2013	51.8%	51.2%
White alone, percent, 2013 (a)	75.7%	79.1%
Black or African American alone, percent, 2013 (a)	19.9%	17.0%
American Indian and Alaska Native alone, percent, 2013 (a)	0.6%	0.4%
Asian alone, percent, 2013 (a)	2.1%	1.6%
Native Hawaiian and Other Pacific Islander alone, percent, 2013 (a)	0.2%	0.1%
Two or More Races, percent, 2013	1.6%	1.7%
Hispanic or Latino, percent, 2013 (b)	4.9%	4.9%
White alone, not Hispanic or Latino, percent, 2013	71.7%	74.9%
Living in same house 1 year & over, percent, 2009-2013	83.8%	84.6%
Foreign born persons, percent, 2009-2013	4.9%	4.6%
Language other than English spoken at home, pct age 5+, 2009-2013	6.7%	6.6%
High school graduate or higher, percent of persons age 25+, 2009-2013	86.3%	84.4%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	27.2%	23.8%
Veterans, 2009-2013	25,822	484,901
Mean travel time to work (minutes), workers age 16+, 2009-2013	21.5	24.3
Housing units, 2013	152,989	2,840,914
Homeownership rate, 2009-2013	64.9%	67.8%
Housing units in multi-unit structures, percent, 2009-2013	24.2%	18.3%
Median value of owner-occupied housing units, 2009-2013	$154,200	$139,200
Households, 2009-2013	135,496	2,475,195
Persons per household, 2009-2013	2.45	2.52
Per capita money income in past 12 months (2013 dollars), 2009-2013	$27,229	$24,409
Median household income, 2009-2013	$46,702	$44,298
Persons below poverty level, percent, 2009-2013	16.6%	17.6%

Business QuickFacts	Hamilton County	Tennessee
Private nonfarm establishments, 2013	8,712	130,819[1]
Private nonfarm employment, 2013	178,107	2,394,068[1]
Private nonfarm employment, percent change, 2012-2013	-0.8%	2.1%[1]
Nonemployer establishments, 2013	23,409	471,026

Bradley County, Tennessee

People QuickFacts	Bradley County	Tennessee
Population, 2014 estimate	102,975	6,549,352
Population, 2013 estimate	101,873	6,497,269
Population, 2010 (April 1) estimates base	98,963	6,346,275
Population, percent change - April 1, 2010 to July 1, 2014	4.1%	3.2%
Population, percent change - April 1, 2010 to July 1, 2013	2.9%	2.4%
Population, 2010	98,963	6,346,105
Persons under 5 years, percent, 2013	5.7%	6.2%
Persons under 18 years, percent, 2013	22.4%	23.0%
Persons 65 years and over, percent, 2013	15.4%	14.7%
Female persons, percent, 2013	51.3%	51.2%
White alone, percent, 2013 (a)	91.9%	79.1%
Black or African American alone, percent, 2013 (a)	4.7%	17.0%
American Indian and Alaska Native alone, percent, 2013 (a)	0.6%	0.4%
Asian alone, percent, 2013 (a)	1.1%	1.6%
Native Hawaiian and Other Pacific Islander alone, percent, 2013 (a)	0.1%	0.1%
Two or More Races, percent, 2013	1.7%	1.7%
Hispanic or Latino, percent, 2013 (b)	5.4%	4.9%
White alone, not Hispanic or Latino, percent, 2013	87.4%	74.9%
Living in same house 1 year & over, percent, 2009-2013	83.5%	84.6%
Foreign born persons, percent, 2009-2013	4.1%	4.6%
Language other than English spoken at home, pct age 5+, 2009-2013	6.1%	6.6%
High school graduate or higher, percent of persons age 25+, 2009-2013	82.4%	84.4%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	18.5%	23.8%
Veterans, 2009-2013	7,200	484,901
Mean travel time to work (minutes), workers age 16+, 2009-2013	21.6	24.3
Housing units, 2013	42,043	2,840,914
Homeownership rate, 2009-2013	67.0%	67.8%
Housing units in multi-unit structures, percent, 2009-2013	17.6%	18.3%
Median value of owner-occupied housing units, 2009-2013	$138,900	$139,200
Households, 2009-2013	37,603	2,475,195
Persons per household, 2009-2013	2.59	2.52
Per capita money income in past 12 months (2013 dollars), 2009-2013	$21,649	$24,409
Median household income, 2009-2013	$41,083	$44,298
Persons below poverty level, percent, 2009-2013	19.8%	17.6%

Business QuickFacts	Bradley County	Tennessee
Private nonfarm establishments, 2013	1,881	130,819[1]
Private nonfarm employment, 2013	37,734	2,394,068[1]
Private nonfarm employment, percent change, 2012-2013	0.5%	2.1%[1]

U.S. Census Quick Facts

QuickFacts Beta

All Topics

	MARION COUNTY, TENNESSEE	UNITED STATES
People		
Population estimates, July 1, 2014, (V2014)	NA	318,857,056
Population estimates base, April 1, 2010, (V2014)	NA	308,758,105
Population, percent change - April 1, 2010 (estimates base) to July 1, 2014, (V2014)	NA	3.3%
Population estimates, July 1, 2013, (V2013)	28,374	316,128,839
Population estimates base, April 1, 2010, (V2013)	28,232	308,747,716
Population, percent change - April 1, 2010 (estimates base) to July 1, 2013, (V2013)	0.5%	2.4%
Persons under 5 years, percent, July 1, 2013, (V2013)	5.1%	6.3%
Persons under 18 years, percent, July 1, 2013, (V2013)	21.5%	23.3%
Persons 65 years and over, percent, July 1, 2013, (V2013)	17.7%	14.1%
Female persons, percent, July 1, 2013, (V2013)	50.8%	50.8%
White alone, percent, July 1, 2013, (V2013) (a)	93.7%	77.7%
Black or African American alone, percent, July 1, 2013, (V2013) (a)	4.0%	13.2%
American Indian and Alaska Native alone, percent, July 1, 2013, (V2013) (a)	0.5%	1.2%
Asian alone, percent, July 1, 2013, (V2013) (a)	0.5%	5.3%
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2013, (V2013) (a)	Z	0.2%
Two or More Races, percent, July 1, 2013, (V2013)	1.4%	2.4%
Hispanic or Latino, percent, July 1, 2013, (V2013) (b)	1.5%	17.1%
White alone, not Hispanic or Latino, percent, July 1, 2013, (V2013)	92.4%	62.6%
Population, Census, April 1, 2010	28,237	308,745,538
Persons under 5 years, percent, April 1, 2010	5.6%	6.5%
Persons under 18 years, percent, April 1, 2010	21.8%	24.0%
Persons 65 years and over, percent, April 1, 2010	15.9%	13.0%
Female persons, percent, April 1, 2010	50.9%	50.8%
White alone, percent, April 1, 2010 (a)	93.9%	72.4%
Black or African American alone, percent, April 1, 2010 (a)	3.6%	12.6%
American Indian and Alaska Native alone, percent, April 1, 2010 (a)	0.4%	0.9%
Asian alone, percent, April 1, 2010 (a)	0.4%	4.8%
Native Hawaiian and Other Pacific Islander alone, percent, April 1, 2010 (a)	Z	0.2%
Two or More Races, percent, April 1, 2010	1.2%	2.9%
Hispanic or Latino, percent, April 1, 2010 (b)	1.3%	16.3%
White alone, not Hispanic or Latino, percent, April 1, 2010	93.2%	63.7%
Housing units, July 1, 2013, (V2013)	12,929	132,802,859
Housing units, April 1, 2010	12,954	131,704,730
Households, 2009-2013	11,226	115,610,216
Persons per household, 2009-2013	2.49	2.63
High school graduate or higher, percent of persons age 25 years+, 2009-2013	76.1%	86.0%
Bachelor's degree or higher, percent of persons age 25 years+, 2009-2013	15.4%	28.8%
Veterans, 2009-2013	2,042	21,263,779
With a disability, under age 65 years, percent, 2009-2013	17.0%	8.4%

↓ MARION

Living in same house 1 year ago, percent of persons age 1 year+, 2009-2013	91.4%	84.9%
Foreign born persons, percent, 2009-2013	0.8%	12.9%
Language other than English spoken at home, percent of persons age 5 years+, 2009-2013	1.8%	20.7%
In civilian labor force, total, percent of population age 16 years+, 2009-2013	54.5%	63.8%
In civilian labor force, female, percent of population age 16 years+, 2009-2013	48.0%	59.0%
Mean travel time to work (minutes), workers age 16 years+, 2009-2013	28.4	25.5
Median household income (in 2013 dollars), 2009-2013	$41,268	$53,046
Per capita income in past 12 months (in 2013 dollars), 2009-2013	$21,399	$28,155
Owner-occupied housing unit rate, 2009-2013	73.8%	64.9%
Median value of owner-occupied housing units, 2009-2013	$118,900	$176,700
Median selected monthly owner costs -without a mortgage, 2009-2013	$346	$452
Median gross rent, 2009-2013	$597	$904
Persons without health insurance, under age 65 years, percent	⚠ 16.2%	⚠ 15.3%
Persons in poverty, percent	⚠ 18.5%	⚠ 14.5%
Median selected monthly owner costs -with a mortgage, 2009-2013	$1,031	$1,540
Businesses		
Total employer establishments, 2012	422	7,431,808
Total employment, 2012	5,254	115,938,468
Total annual payroll, 2012	160,825	5,414,255,995
Total employment, percent change, 2011-2012	0.1%	2.2%
Total nonemployer establishments, 2012	1,740	22,735,915
All firms, 2007	1,974	27,092,908
Men-owned firms, 2007	1,002	13,900,554
Women-owned firms, 2007	554	7,792,115
Minority-owned firms, 2007	S	5,759,209
Nonminority-owned firms, 2007	1,756	20,100,926
Veteran-owned firms, 2007	125	2,447,608
Nonveteran-owned firms, 2007	1,648	22,627,611
Total accommodation and food services sales, 2007 ($1,000) (c)	32,734	613,795,732
Total health care and social assistance receipts/revenue, 2007 ($1,000) (c)	D	1,668,276,808
Total manufacturers shipments, 2007 ($1,000) (c)	D	5,319,456,312
Total merchant wholesaler sales, 2007 ($1,000) (c)	D	4,174,286,516
Total retail sales, 2007 ($1,000) (c)	286,563	3,917,663,456
Total retail sales per capita, 2007 (c)	$10,227	$12,990
Building permits, 2013	65	990,822
Geography		
Population per square mile, 2010	56.7	87.4
Land area in square miles, 2010	498.16	3,531,905.43
FIPS Code	47115	00
Metropolitan or Micropolitan Statistical Area	Chattanooga, TN-GA Metro Area	

⚠ This geographic level of poverty and health estimates are not comparable to other geographic levels of these estimates

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable. Click the Quick Info 'i' icon to the left of each row in TABLE view to learn about sampling error.

The vintage year (e.g., V2014) refers to the final year of the series (2010 thru 2014).
Different vintage years of estimates are not comparable.

(a) Includes persons reporting only one race
(b) Hispanics may be of any race, so also are included in applicable race categories
(c) Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

D Suppressed to avoid disclosure of confidential information
F Fewer than 25 firms
FN Footnote on this item in place of data
NA Not available
S Suppressed; does not meet publication standards

Walker County, Georgia

People QuickFacts	Walker County	Georgia
Population, 2014 estimate	68,218	10,097,343
Population, 2013 estimate	68,317	9,994,759
Population, 2010 (April 1) estimates base	68,756	9,688,681
Population, percent change - April 1, 2010 to July 1, 2014	-0.8%	4.2%
Population, percent change - April 1, 2010 to July 1, 2013	-0.6%	3.2%
Population, 2010	68,756	9,687,653
Persons under 5 years, percent, 2013	5.6%	6.7%
Persons under 18 years, percent, 2013	22.8%	24.9%
Persons 65 years and over, percent, 2013	16.2%	12.0%
Female persons, percent, 2013	50.8%	51.1%
White alone, percent, 2013 (a)	93.3%	62.5%
Black or African American alone, percent, 2013 (a)	4.4%	31.4%
American Indian and Alaska Native alone, percent, 2013 (a)	0.3%	0.5%
Asian alone, percent, 2013 (a)	0.5%	3.7%
Native Hawaiian and Other Pacific Islander alone, percent, 2013 (a)	0.1%	0.1%
Two or More Races, percent, 2013	1.4%	1.9%
Hispanic or Latino, percent, 2013 (b)	1.8%	9.2%
White alone, not Hispanic or Latino, percent, 2013	91.7%	54.8%
Living in same house 1 year & over, percent, 2009-2013	83.8%	83.6%
Foreign born persons, percent, 2009-2013	1.1%	9.7%
Language other than English spoken at home, pct age 5+, 2009-2013	2.4%	13.3%
High school graduate or higher, percent of persons age 25+, 2009-2013	79.1%	84.7%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	14.0%	28.0%
Veterans, 2009-2013	5,925	690,208
Mean travel time to work (minutes), workers age 16+, 2009-2013	25.9	27.0
Housing units, 2013	29,901	4,109,896
Homeownership rate, 2009-2013	72.6%	65.1%
Housing units in multi-unit structures, percent, 2009-2013	8.9%	20.5%
Median value of owner-occupied housing units, 2009-2013	$104,700	$151,300
Households, 2009-2013	26,191	3,518,097
Persons per household, 2009-2013	2.57	2.71
Per capita money income in past 12 months (2013 dollars), 2009-2013	$20,865	$25,182
Median household income, 2009-2013	$39,963	$49,179
Persons below poverty level, percent, 2009-2013	16.7%	18.2%

Business QuickFacts	Walker County	Georgia
Private nonfarm establishments, 2013	707	217,559[1]
Private nonfarm employment, 2013	9,999	3,458,050[1]
Private nonfarm employment, percent change, 2012-2013	-1.8%	2.0%[1]
Nonemployer establishments, 2013	1,122	707,104

Catoosa County, Georgia

People QuickFacts	Catoosa County	Georgia
Population, 2014 estimate	65,621	10,097,343
Population, 2013 estimate	65,335	9,994,759
Population, 2010 (April 1) estimates base	63,940	9,688,681
Population, percent change - April 1, 2010 to July 1, 2014	2.6%	4.2%
Population, percent change - April 1, 2010 to July 1, 2013	2.2%	3.2%
Population, 2010	63,942	9,687,653
Persons under 5 years, percent, 2013	5.7%	6.7%
Persons under 18 years, percent, 2013	24.0%	24.9%
Persons 65 years and over, percent, 2013	15.4%	12.0%
Female persons, percent, 2013	51.4%	51.1%
White alone, percent, 2013 (a)	93.9%	62.5%
Black or African American alone, percent, 2013 (a)	2.6%	31.4%
American Indian and Alaska Native alone, percent, 2013 (a)	0.4%	0.5%
Asian alone, percent, 2013 (a)	1.4%	3.7%
Native Hawaiian and Other Pacific Islander alone, percent, 2013 (a)	0.1%	0.1%
Two or More Races, percent, 2013	1.6%	1.9%
Hispanic or Latino, percent, 2013 (b)	2.7%	9.2%
White alone, not Hispanic or Latino, percent, 2013	91.6%	54.8%
Living in same house 1 year & over, percent, 2009-2013	86.3%	83.6%
Foreign born persons, percent, 2009-2013	2.3%	9.7%
Language other than English spoken at home, pct age 5+, 2009-2013	3.7%	13.3%
High school graduate or higher, percent of persons age 25+, 2009-2013	82.3%	84.7%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	17.5%	28.0%
Veterans, 2009-2013	4,805	690,208
Mean travel time to work (minutes), workers age 16+, 2009-2013	22.3	27.0
Housing units, 2013	26,615	4,109,896
Homeownership rate, 2009-2013	72.6%	65.1%
Housing units in multi-unit structures, percent, 2009-2013	12.9%	20.5%
Median value of owner-occupied housing units, 2009-2013	$130,200	$151,300
Households, 2009-2013	23,941	3,518,097
Persons per household, 2009-2013	2.68	2.71
Per capita money income in past 12 months (2013 dollars), 2009-2013	$21,690	$25,182
Median household income, 2009-2013	$47,087	$49,179
Persons below poverty level, percent, 2009-2013	13.9%	18.2%

Business QuickFacts	Catoosa County	Georgia
Private nonfarm establishments, 2013	892	217,559[1]
Private nonfarm employment, 2013	11,569	3,458,050[1]
Private nonfarm employment, percent change, 2012-2013	-0.1%	2.0%[1]

SUPPORT LETTERS

	Female				Female	Male					
COUNTY	0 - 18	19 - 20	21 - 64	65 -->	Total	0 - 18	19 - 20	21 - 64	65 -->	Male Total	Grand Total
JACKSON	648	62	689	133	1,532	689	60	393	95	1,237	2,769
JEFFERSON	3,109	243	2,920	477	6,749	3,255	200	1,439	198	5,092	11,841
JOHNSON	976	106	1,081	278	2,441	1,065	66	689	153	1,973	4,414
KNOX	19,329	1,510	19,172	2,413	42,424	20,195	1,153	8,281	1,074	30,703	73,127
LAKE	453	38	606	152	1,249	539	41	269	65	914	2,163
LAUDERDALE	1,980	188	2,056	309	4,533	2,073	155	863	125	3,216	7,749
LAWRENCE	2,577	236	2,502	411	5,726	2,785	157	1,270	152	4,364	10,090
LEWIS	770	70	723	127	1,690	756	74	331	57	1,218	2,908
LINCOLN	1,940	146	1,783	284	4,153	2,031	121	869	114	3,135	7,288
LOUDON	2,373	201	2,040	267	4,881	2,482	110	968	106	3,666	8,547
MACON	1,771	158	1,600	250	3,779	1,839	127	796	116	2,878	6,657
MADISON	6,499	496	6,536	818	14,349	6,533	383	2,298	329	9,543	23,892
MARION	1,761	174	1,889	236	4,060	1,784	119	828	129	2,860	6,920
MARSHALL	1,746	119	1,607	169	3,641	1,842	102	668	71	2,683	6,324
MAURY	4,834	333	4,453	529	10,149	5,085	270	1,728	189	7,272	17,421
MCMINN	2,997	270	3,047	510	6,824	3,188	188	1,406	215	4,997	11,821
MCNAIRY	1,732	175	1,965	362	4,234	1,876	137	1,096	186	3,295	7,529
MEIGS	763	70	791	85	1,709	810	58	408	43	1,319	3,028
MONROE	2,785	264	2,848	483	6,380	3,038	191	1,436	230	4,895	11,275
MONTGOMERY	8,712	615	8,289	664	18,280	9,062	451	2,847	228	12,588	30,868
MOORE	209	19	173	45	446	254	28	80	16	378	824
MORGAN	1,208	103	1,155	189	2,655	1,278	100	596	99	2,073	4,728
OBION	1,984	174	2,063	291	4,512	2,091	108	842	117	3,158	7,670
OVERTON	1,204	138	1,223	265	2,830	1,315	113	674	138	2,240	5,070
PERRY	540	37	471	77	1,125	521	48	270	35	874	1,999
PICKETT	252	25	276	86	639	295	27	153	45	520	1,159
POLK	968	110	1,015	155	2,248	1,033	67	531	71	1,702	3,950
PUTNAM	4,149	346	4,135	717	9,347	4,313	269	2,169	320	7,071	16,418
RHEA	2,334	196	2,169	344	5,043	2,381	167	1,054	135	3,737	8,780
ROANE	2,604	230	2,971	512	6,317	2,894	178	1,573	219	4,864	11,181
ROBERTSON	3,798	286	2,990	366	7,440	4,025	213	1,199	165	5,602	13,042
RUTHERFORD	13,264	1,051	11,070	975	26,360	13,783	744	3,946	413	18,886	45,246
SCOTT	1,871	166	2,019	381	4,437	1,987	124	1,095	191	3,397	7,834
SEQUATCHIE	998	85	999	142	2,224	1,018	74	532	52	1,676	3,900
SEVIER	5,394	413	4,574	458	10,839	5,779	311	1,878	163	8,131	18,970
SHELBY	74,119	5,729	66,348	6,764	152,960	75,749	4,911	21,455	2,797	104,912	257,872
SMITH	1,066	109	1,048	161	2,384	1,092	59	482	64	1,697	4,081
STEWART	722	58	767	114	1,661	761	49	381	52	1,243	2,904
SULLIVAN	7,791	700	8,568	1,281	18,340	8,265	538	4,225	561	13,589	31,929
SUMNER	7,697	603	7,012	768	16,080	8,025	462	2,731	310	11,528	27,608
TIPTON	3,653	331	3,370	370	7,724	3,793	285	1,279	132	5,489	13,213
TROUSDALE	521	63	481	69	1,134	488	46	225	33	792	1,926
UNICOI	932	97	992	252	2,273	1,033	70	470	119	1,692	3,965
UNION	1,357	129	1,179	159	2,824	1,294	93	672	87	2,146	4,970
VAN BUREN	315	32	320	61	728	340	24	176	48	588	1,316
WARREN	2,818	224	2,685	423	6,150	2,937	169	1,252	194	4,552	10,702
WASHINGTON	5,613	480	6,260	947	13,300	5,764	367	2,896	422	9,449	22,749
WAYNE	810	66	826	165	1,867	842	80	419	71	1,412	3,279
WEAKLEY	1,798	182	1,942	311	4,233	1,859	132	926	107	3,024	7,257
WHITE	1,720	150	1,711	304	3,885	1,824	118	927	123	2,992	6,877
WILLIAMSON	3,185	206	2,548	368	6,307	3,322	201	1,022	141	4,686	10,993
WILSON	4,896	359	4,484	467	10,206	5,074	271	1,789	190	7,324	17,530
Other	2,481	245	2,773	117	5,616	2,666	164	1,144	82	4,056	9,672
Grand Total	376366	30433	357383	46942	811124	392167	23944	151201	20568	587880	1,399,004

Reports include some membership additions that are the result of retroactivity; however, additional retroactivity may still occur. The "Other" county category reflects recipients who are Tennessee residents for which their domicile is temporarily located outside of the state.

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

July 1, 2015

John Wellborn, Consultant
Development Support Group
4219 Hillsboro Road
Nashville, TN 37215

RE: Certificate of Need Application -- Chattanooga Endoscopy Center - CN1506-024
The relocation of The Chattanooga Endoscopy Center, an existing single specialty ASTC limited to endoscopy, from 2341 McCallie Avenue, Plaza 3, Suite 303 to leased space on the first floor of The Riverside Business Center at 1501 Riverside Drive, Suite 117, Chattanooga, TN, a distance of approximately 3 miles. As a part of the project, the applicant also seeks CON approval to expand its existing surgical complement from 3 to 5 procedure rooms with a 6th procedure room to be shelled in for potential future expansion. The estimated project cost is $5,853,848.00.

Dear Mr. Wellborn:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on July 1, 2015. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on September 23, 2015.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(2) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(3) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: July 1, 2015

RE: Certificate of Need Application Chattanooga Endoscopy Center - CN1506-024

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on July 1, 2015 and end on September 1, 2015.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: John Wellborn, Consultant

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Chattanooga Times Free Press, which is a newspaper of general circulation in Hamilton County, Tennessee, on or before Tuesday, June 9, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that the Chattanooga Endoscopy Center (an ambulatory surgical treatment center, formerly named the Digestive Disorders Endoscopy Center), owned by The Chattanooga Endoscopy ASC, LLC (a limited liability company), and managed by AmSurg Corp (a corporation) intends to file an application for a Certificate of Need to relocate from 2341 McCallie Avenue Plaza 3, Suite 303, Chattanooga, TN 37404, to the Riverside Business Center at 1501 Riverside Drive, Suite 117, Chattanooga, TN 37406, a distance of approximately 3 miles, and to expand its surgical room complement from three (3) procedure rooms to five (5) procedure rooms, with a sixth room shelled in for potential future expansion. The project cost under CON rules is estimated at approximately $8,624,000, which includes space lease payments for fifteen years and the value of equipment being relocated.

This facility is currently licensed by the Board for Licensing Health Care Facilities as a single specialty ambulatory surgical treatment center limited to endoscopy. The relocation will not change the facility's license classification. The project does not contain major medical equipment or initiate or discontinue any other health service; and it will not affect any facility's licensed bed complements.

The anticipated date of filing the application is on or before June 15, 2015. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

John L. Wellborn 6-9-15 jwdsg@comcast.net

(Signature) (Date) (E-mail Address)

Supplemental #1
-Original-

Chattanooga Endoscopy Center

CN1506-024

SUPPLEMENTAL #1
June 22, 2015
12:58 pm

June 22, 2015

Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application CN1506-024
Chattanooga Endoscopy Center

Dear Mr. Grimm:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. **Section A, Applicant Profile, Item 3**

   Given the significant increase in new physicians in the past year, does the applicant intend to expand the ownership of the LLC in the future? If so, how might the ownership interests change to accommodate the increased participation in ownership of the LLC?

   At present, only one additional physician has expressed interest in becoming an owner but not for at least a year. The CEC has no plans to add physicians in the foreseeable future other than that person. If a new owner is approved by the Board, all existing owners will then dilute their percentages of membership to accommodate the new member, with all members at the same percentage of membership interest.

2. **Section A, Applicant Profile, Item 5**

   The February 2015 amendment to the original management services agreement effective February 1, 2001 is noted. Was there a change in the management of the ASTC prior to that time from its original licensure by TDH in July 1998? Please provide a brief discussion of AmSurg's historical relationship with the applicant ASTC.

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

The facility (then Digestive Disorders Endoscopy Center) was founded and opened in August of 1998 by Richard Krause, MD (who is still today a member of the medical staff). AMSURG purchased a 51% stake in the company in July of 1999. The facility and AMSURG entered into a management services agreement for provision of certain services in February of 2001 to coincide with an amendment to the partnership's Operating Agreement. This management services agreement was renewed in 2002 and was amended in 2004 (to reflect a negotiated upon adjustment in compensation for services rendered from 4% of Net Revenues/$90,000 cap to a flat annual fee in the amount of $48,000 paid in equal monthly installments). In 2015, the former partner members (AMSURG = 51%; Henry Paik, MD = 24.5%; Richard Sadowitz, MD = 24.5%) agreed to dilute their ownership interests to allow for the entrance of the new physician partners named in this project. Upon diluting from 51% to 35%, the management services agreement between AMSURG and the facility was re-negotiated and agreed upon by all parties in February of 2015 to reflect services rendered at a fair market fee of 3% of Net Revenues.

3. Section B, Project Description, Item 1.
Please provide the following additional information for the highlights noted in the executive summary:

3a. Confirming original CON approved in 9608-060A with any limitations as to specialty or procedure rooms.

There were no limitations. Attached following this page are copies of the original CON document and supporting pages from the application and HSDA. But research in the original records of the facility (built by another owner) show that it opened with three rooms finished out (construction complete) but only two rooms equipped. They remained in that status until this year, when AmSurg equipped and opened its third authorized room.

3b. Addition of 3rd procedure room in early 2015 – please confirm that the addition was below the $2 million CON threshold for construction projects that apply to this type facility.

See response 3a, which may make this question moot. The project to open the third procedure room and build expanded support spaces cost $1,125,000--$375,000 of construction and $750,000 of new and replacement equipment. The project equipped the third room and replaced outdated equipment in the two operational rooms. Expanded areas included the waiting room, the pre- and post-operative stations, and several support areas.

SUPPLEMENTAL #1

June 22, 2015
12:58 pm

STATE OF TENNESSEE
HEALTH FACILITIES COMMISSION

Certificate of Need CN9608-060A is hereby granted under the provisions of T.C.A. §68-11-101, *et seq.*, and the rules and regulations issued thereunder by this Commission

to The Center for Digestive Disorders and Clinical Research, P.C.
2341 McCallie Avenue, Suite 303
Chattanooga, TN 37404

for The Center for Digestive Disorders and Clinical Research, P.C.
** d/b/a Digestive Disorders Endoscopy Center

This Certificate is issued for the construction and operation of an outpatient surgery center for the provision of endoscopic procedures

on the premises located at 2341 McCallie Avenue, Suite 303
Chattanooga, TN 37404

for an estimated project cost of $800,000.00

The Expiration Date for this Certificate of Need is

January 1, 1999

or upon completion of the action for which the Certificate of Need was granted, whichever occurs first. After the effective date, this Certificate of Need is null and void.

** Pursuant to T.C.A. §68-11-108(a) and Commission Rule 0720- 3-.06(8)(a)(3) [illegible] date of an [illegible]

Date Approved November 14, 1996

Date Issued December 16, 1996

Date Reissued * April 4, 1997

* To Reflect clerical change pursuant to Commission Rule 0720-3- 06(8)

Date Approved ** April 22, 1998

Chairman

Secretary

Chairman

Secretary

HF-0022 (Rev. 5-93)

HEALTH FACILITIES COMMISSION MEETING
NOVEMBER 14, 1996
APPLICATION SUMMARY

NAME OF PROJECT:	The Center for Digestive Disorders and Clinical Research, PC
PROJECT NUMBER:	CN9608-060
ADDRESS:	2341 McCallie Avenue, Suite 201 Chattanooga (Hamilton County), TN 37404
LEGAL OWNER:	The Center for Digestive Disorders and Clinical Research, P.C. 2341 McCallie Avenue, Suite 201 Chattanooga (Hamilton County), TN 37404
OPERATING ENTITY:	Not Applicable
CONTACT PERSON:	E. Graham Baker, Jr., Esquire (615)377-7740
DATE FILED:	August 15, 1996
PROJECT COST:	$800,000
FINANCING:	Commercial loan

DESCRIPTION:

The applicant, The Center for Digestive Disorders and Clinical Research, PC, is seeking approval for the construction and operation of an outpatient surgery center for the provision of endoscopic procedures. The facility is being developed by Calisher and Lazerine Associates of Huntington Beach, California. The facility will contain 2,500 square feet of leased space in a medical office building located at 2341 McCallie Avenue in Chattanooga, Hamilton County, Tennessee. The new facility will apply for Medicare, Medicaid, and TennCare certification.

The Center for Digestive Disorders and Clinical Research will contain three (3) endoscopy rooms plus related space. Line drawings of the proposed facility are attached to this summary. The Center is currently located at Parkridge Medical Center and has four (4) physicians on staff. The applicant is projecting 2,632 procedures in the first year and 2,710 procedures the second year following project completion.

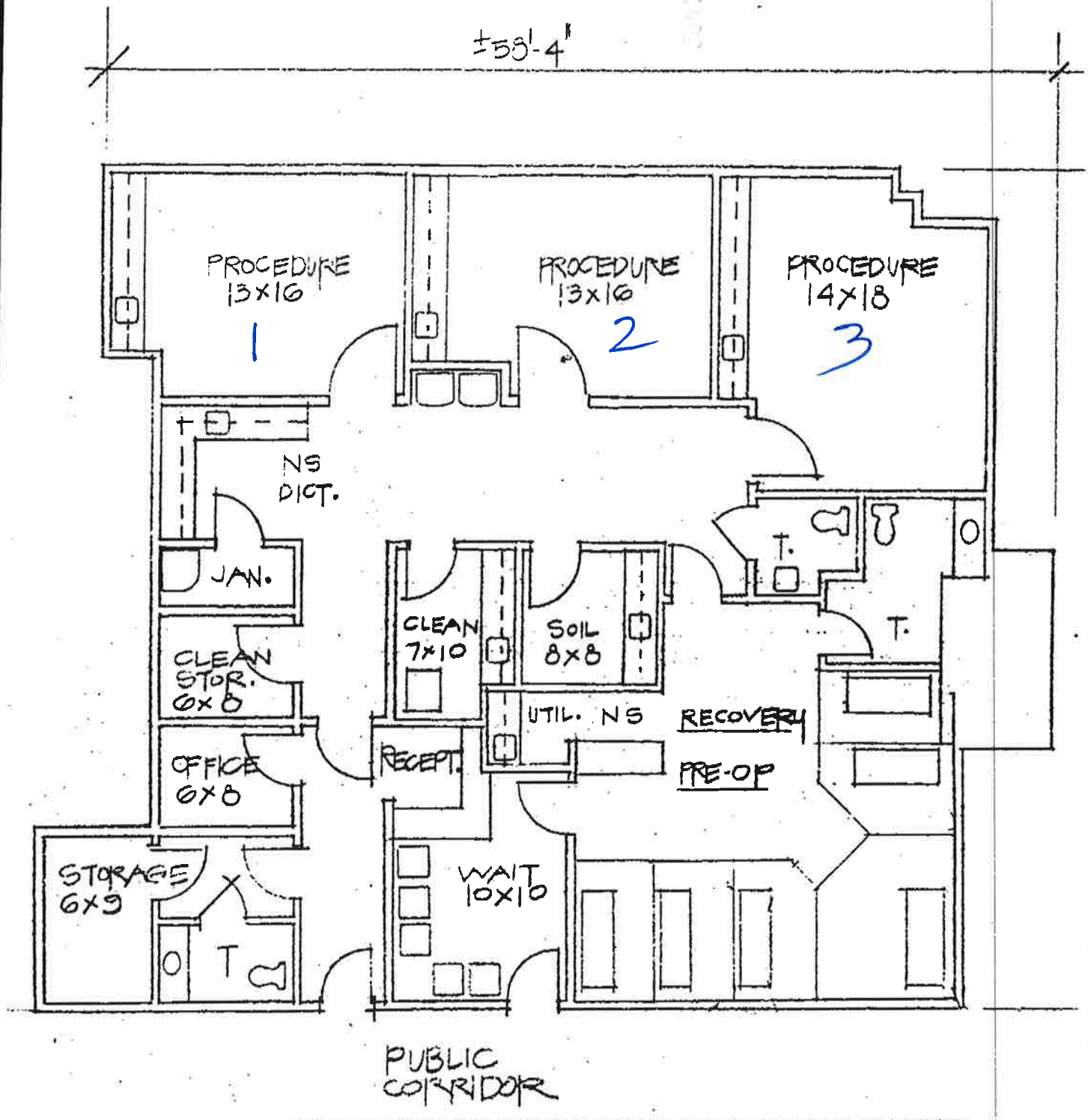
The total estimated project cost is $800,000. The cost includes $125,000 fair market value of the leased space. The project will be financed with a commercial loan from First

SUPPLEMENTAL #1

ATTACHMENT III

June 22, 2015

12:58 pm



3c. Given the relatively low patient origin from both Bradley and Marion Counties – whether new expanded physician staff is bringing patients from these areas.

They will. Following is a comparison table. It shows the CEC's Badley and Marion County patient origin in FYE 2014 (from its JAR); and it compares it to the patient origin from those counties projected in the application's Table Seven, page 35. The projected data in the application was aggregated from individual practices' patient origin, to give a complete picture of future patient origin.

Patient Origin from Bradley and Marion Counties, 2014 and 2018				
	CEC, FYE2014 JAR		CEC, Projected CY2018	
	Patients	Percent	Patients	Percent
Bradley Co.	86	3.7%	583	5.1%
Marion Co.	74	3.2%	401	3.5%
Total, 2 Cos.	***160***	***6.9%***	***984***	***8.6%***

Source: CON application Table Seven; CEC 2014 Joint Annual Report

3d. General overview of "special needs" of service area drawing from page 38 with specific reference to the incidence of colon cancer in the primary service area.

The Center of Disease Controls website shows that colorectal cancer incidence in Tennessee is 40.1 to 42.6 persons per 100,000 population, in the third highest national quartile. However, Tennessee is one of twelve States in the highest quartile for deaths from that disease, at 16.5 to 19.9 persons per 100,000 population. This is linked to the fact that only 59.3% to 63.5% of Tennessee adults age 50-75 years are "up to date", i.e., compliant with, recommended periodic colon cancer screening guidelines. Screening endoscopies are essential to identify and surgically remove pre-cancerous polyps and early-stage colon cancers.

Potential Colon Cancer Patients, Primary Service Area			
PSA County	Rate/100,000	2015 Population	Predicted 2015 Cases
Hamilton	40.1 to 42.6	349,273	140-149
Bradley	40.1 to 42.6	104,364	42-45
Marion	40.1 to 42.6	28,652	12-12
Walker	40.1 to 42.6	67,823	27-29
Catoosa	40.1 to 42.6	66,202	26-28
PSA Total	40.1 to 42.6	*616,314*	*247-263*

Source: CDC; TDH

3e. It appears that the expanded medical staff has a large patient base with over 31,000 total patient visits in 2014 (page 34). Of the 15 medical staff members, please briefly describe where they practice in the service area by noting location of private practices and hospital admitting privileges.

Attached after this page is a table showing where all of the 15 staff members have office practices and have surgical privileges. Bold (**X**) indicates where they performed significant numbers of endoscopies in 2014. Only one has privileges outside of Hamilton County.

While physicians in the Galen Group do have privileges at Erlanger's Plaza surgery center, the Group tells CEC that their annual utilization of the Plaza facility is only a few patients every two to three months, who have insurance coverage only at an Erlanger facility.

3f. Other than endoscopies, what other related types of procedures do the gastroenterologists perform at the facility? If possible, please list by CPT code.

They do, and will, perform only endoscopies at CEC. A list of procedures approved for the CEC is attached following this page.

3g. The applicant notes other physicians without ownership interests in the LLC perform endoscopies at the facility. As such, is the facility open to use by others who are not members of the LLC that might apply for privileges at the facility?

It is an open medical staff. As stated on page 11 of the application, there are now three physicians on staff who are not owners (identified in 3e above). Only one more has been identified as a potential owner in the future. The surgical hours needed by the current 15-member staff are expected to leave very little surgical capacity for new physicians who might request privileges.

CEC Medical Staff--Locations of Surgical Privileges
(Bold X Indicates Primary Surgical Locations)

		Hamilton County Facilities											Bradley County Facilities			Marion County Facilities
	Office Location(s)	Associates of Memorial/Mission OP Surgery	Chattanooga Endoscopy Center	Physicians Surgery Center of Chattanooga	Plaza Surgery Center	Erlanger Medical Center	Erlanger East Hospital	Erlanger North Hospital	Memorial Healthcare System	Memorial North Park	Parkridge Medical Center	Parkridge East Hospital	Surgery Center of Cleveland	Skyridge Medical Center	Skyridge Medical Center Westside	Parkridge West Hospital
Physician																
1. Sumeet Bhushan, MD	***2200 East 3rd St Ste 200 Chattanooga, TN 37404** 1651 Gunbarrel Rd. Ste 102 Chattanooga, TN 37421 2051 Hamill Rd. Ste 204 Hixson, TN 37343		**X**		X				**X**	**X**						
2. Chad Charapata, MD	***2200 East 3rd St Ste 200 Chattanooga, TN 37404** 1651 Gunbarrel Rd. Ste 102 Chattanooga, TN 37421		**X**		X				**X**	**X**						
3. David N. Collins, MD	*725 Glenwood Drive Suite 690 Chattanooga, TN 37404		**X**						**X**							
4. Donald Hetzel, MD	***2515 deSales Avenue, Suite 206 Memorial Mission Surgery Center Building Chattanooga, TN 37404** 1651 Gunbarrel Rd. Ste 102 Chattanooga, TN 37421		**X**						**X**		X					
5. Scott Manton, MD	***2515 deSales Avenue, Suite 206 Memorial Mission Surgery Center Building Chattanooga, TN 37404** 1651 Gunbarrel Rd. Ste 102 Chattanooga, TN 37421		**X**						**X**		X					
6. Gregory Olds, MD	***2200 East 3rd St Ste 200 Chattanooga, TN 37404** 1651 Gunbarrel Rd. Ste 102 Chattanooga, TN 37421		**X**						**X**	**X**						
7. Henry Paik, MD	***2341 McCallie Ave. Plaza 3, Ste. 406 Chattanooga, TN 37404**		**X**						X		**X**	X				

SUPPLEMENTAL #1
June 22, 2015
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CEC Medical Staff--Locations of Surgical Privileges
(Bold X Indicates Primary Surgical Locations)

		Hamilton County Facilities											Bradley County Facilities			Marion County Facilities
	Office Location(s)	Associates of Memorial/Mission OP Surgery	Chattanooga Endoscopy Center	Physicians Surgery Center of Chattanooga	Plaza Surgery Center	Erlanger Medical Center	Erlanger East Hospital	Erlanger North Hospital	Memorial Healthcare System	Memorial North Park	Parkridge Medical Center	Parkridge East Hospital	Surgery Center of Cleveland	Skyridge Medical Center	Skyridge Medical Center Westside	Parkridge West Hospital
Physician																
8. Vijay Patel, MD	***2515 deSales Avenue, Suite 206 Memorial Mission Surgery Center Building Chattanooga, TN 37404** 1651 Gunbarrel Rd. Ste 102 Chattanooga, TN 37421		**X**						**X**		X					
9.Richard Sadowitz, MD	***2341 McCallie Ave Plaza 3 Suite 403 Chattanooga, TN 37404**		**X**						X		**X**	X				
10. Colleen Schmitt, MD	***2200 East 3rd St Ste 200 Chattanooga, TN 37404** 1651 Gunbarrel Rd. Ste 102 Chattanooga, TN 37421		**X**		X				X	X						
11. Alan Shikoh, MD	***1651 Gunbarrel Rd, STE 102 Chattanooga TN 37421**		**X**						**X**		X					
12. Larry Shuster, MD	***1060 Peerless Crossing, STE 200 Chattanooga, TN 37312** 1651 Gunbarrel Rd. Ste 102 Chattanooga, TN 37421		X		X				**X**	**X**			**X**			
13. Munford Yates, MD	***2200 East 3rd St Ste 200 Chattanooga, TN 37404** 1651 Gunbarrel Rd. Ste 102 Chattanooga, TN 37421		**X**		X				**X**	**X**						
14. Camille Sommer, MD	***2341 McCallie Ave. Plaza 3, Ste. 406 Chattanooga, TN 37404**		**X**						**X**		X	**X**				
15. Richard Krause, MD	***6035 Shallowford Rd, STE 109 Chattanooga, TN 37421**		**X**								**X**					

Source: AmSurg management.

SUPPLEMENTAL #1
June 22, 2015
12:58 pm

SUPPLEMENTAL #1

June 22, 2015
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Approved Procedure List

Chattanooga Endoscopy Center

Procedures approved to be performed at the center:
EGD—43235
EGD with Biopsy—43239
EGD with Polypectomy—43250/43251
EGD with Dilation—43248/43249/
EGD with Sclerotherapy--43243
EGD with Hemostasis Probe--43227
EGD with Bipolar Cautery--43216
EGD with Removal of Foreign body --43247
Dilation –43450/43453
Colonoscopy—45378/G0105/G0121
Colonoscopy with Polypectomy—45384/45385
Colonoscopy with Bipolar cautery—45380
Flexible Sigmoidoscopy—45330
Flexible Sigmoidoscopy with Biopsy—45331
Flexible Sigmoidoscopy with Polypectomy—45333/45338/45346
Hemorrhoidal injection with Hypertonic Saline Enteroscopy -- N/A
Conscious Sedation – N/A
Anoscopy – 46600-46615
Ligation of Hemorrhoids (Banding) – 46221
Peg tube removal—N/A
Monitored Anesthesia Care (MAC) –00740/00810
Minimal Sedation—N/A
Supervision of CRNA – N/A
Supervision of conscious sedation – N/A
Hemorrhoidal banding (CRH technique) -- 46221

4. Section C, Need Item 1, Specific Criteria –ASTC and Construction/Renovation

4a. ASTC, Item 4 - the discussion of impact is noted. Given the comments on pages 25-27, the applicant states that an estimated 9,290 new cases will be brought by the physicians who have been performing cases at other facilities, with most or all at 1 ASTC and 1 hospital in Chattanooga, TN. It is understood that endoscopy utilization in the JAR for hospitals is not available. However, with respect to ASTCs, review of the JAR for Associates Memorial/ Mission revealed that endoscopies accounted for an average of approximately 50% of total procedures from 2012–2014 and total surgical cases declined by approximately 3.3% during the same period. Applying this information and the estimate of 9,290 new cases that will be brought the applicant's ASTC, is any additional insight available to help provide a better measure of the impact to the ASTC? Please briefly discuss.

This week, a CEC physician conferred with administration of the Memorial Mission ASTC, and was told that (a) no GI cases are being performed there now; (b) they expect to put the ASTC into inactive status by the end of June; and (c) it may be converted to an HOPD (hospital-based outpatient department). Based on that, it appears that all of the CEC medical staff have already taken their endoscopies to CEC and to other locations. Assuming that the reported plan of closure does occur, the relocation and expansion of CEC will not have any impact on the Memorial/Mission ASTC because the latter will cease to exist even before the CEC CON application enters the review process.

The applicant is unable to identify where most of the Memorial/Mission ASTC's endoscopies have gone. That is not public information. However, if a significant number have been relocated to any hospital, the cost to payers and/or patients will be significantly higher because Medicare and many insurers pay hospitals some 40% more for these same procedures. If in 2017 those cases being done in area hospitals do relocate to the CEC, that will have a positive impact on the costs of care for those patients.

4b. ASTC, Item 11 – Please provide an update on status of contract with the 4th MCO available in the service area. Does the MCO need more provider members for this type of facility?

AmSurg is in contract negotiation with Amerigroup for all its East Tennessee ASTC's, including the CEC. Credentialing has been submitted for all locations. Modifications to the Amerigroup template contract have been proposed by AmSurg. An Amerigroup manager has been assigned to negotiate the final contract. There is no estimated time frame for Amerigroup to reach a decision. The applicant has not been told that Amerigroup does not need more provider members for this type of facility.

4c. Construction/Renovation, Item 2.b. – Given the metrics provided, it appears that the projected 11,422 endocopy cases estimated by the applicant's physicians amounts to only 57% of the 20,000 or more outpatient cases they performed at all licensed facilities combined. At optimal capacity, it seems that the proposed new facility might require 10 procedure rooms should demand reach levels closer to 20,000 cases per year. Did the applicant consider building a larger facility with more procedure rooms than the 5 built out rooms requested in this CON proposal? Please discuss.

The new location does have adjacent space available for future expansion; and the facility has been designed so that would be possible and efficient to operate.

However, at this time the CEC has no reason to propose more future capacity than six rooms (five operational and one left unequipped for later completion). With six rooms, at 2,500 cases per room optimum scheduling from AmSurg's standpoint, the CEC could perform 15,000 cases. That should be sufficient to meet currently identifiable needs. A significant number of the medical staff's 20,000+ endoscopy cases will always need to remain in a hospital environment due to patient risk factors (age, complications, type of procedure, etc.).

5. Section C, Need Item 5 and 6 (Applicant's Historical and Projected Utilization)
5a. Review of the information and comparison to the JAR revealed some differences in the utilization amounts provided for the applicant. Using the table below, please explain the amounts that differ.

All the tables referenced in your chart are being revised to clarify or to correct those differences.

Following this page are your original table of difference, and then a table with corrections and footnoted explanations.

Following that page are the four revised pages pages 25R, 40R, 43R, and 55R, containing respectively Tables Five, Nine-A, Ten, and Twelve. They have been revised as described on the corrected table of differences.

A copy of the CEC's request to TDH to amend its 2014 JAR to reflect 2,332 patients rather than 2,173 patients is also attached, after the four revised application pages.

Reviewer's Table for Question 5a					
Year	C Need 1 *(table 5, p25)*	C Need 5 *(table 9A, p40)*	C Need 6 *(table 10, p43)*	Historical Data Chart *(p51)*	C, Economic Feasibility,6.B *table 12 (p55)*
2012	NA	2,215	2,215	2,280	NA
2013	NA	2,240	2,240	2,363	NA
2014	2,173	2,173	2,113	2,152	2,332
2015	4,968	NA	5,890	NA	NA

Applicant's Table Showing Corrections and Revisions in the Tables (Amended Case Data Shown in Bold)					
Year	C Need 1 *(table 5, p25)*	C Need 5 *(table 9A, p40)*	C Need 6 *(table 10, p43)*	Historical Data Chart *(p51)*	C, Economic Feasibility,6.B *table 12 (p55)*
2012		2,215 *FY data*	2,215 *FY data*	2,280 *CY data*	
2013		2,240 *FY data*	2,240 *FY data*	2,363 *CY data*	
2014	**2,332** *FY data*	**2,332** *FY data*	**2,332** *FY data*	2,152 *CY data*	**2,332** *FY data*
2015	4,968 *CY Run Rate*		5,890 *CY Projection*		

Notes:

1. The cases shown on the Historic Data Chart 2012-14 are calendar year data from AmSurg and have been verified to be correct.

2. The 2015 Table 5, p. 25 entry, 4,968 cases, is a "run rate" number illustrating the annualization of the April rate of 414 patients per month. It is not a utilization projection for the project. It only only illustrates the current monthly escalation of cases and their dramatic potential impact on annual utilization in future years.

3. The 2,173 cases in the reviewer's table for FYE 2014 (and the 2,113 which was a typographical error) were 2,173 patients CEC reported in its 2014 JAR. However, in preparing the application AmSurg discovered that there were 2,332 cases in FYE 2014. The bold entries in the table show those changes. This error has been reported to TDH; a copy of that letter is attached after the revised pages below.

The Applicant's Utilization

However, under this criterion, the applicant's "current" utilization is relevant. In 2014, with only 4 gastroenterologists actively using the facility, and only 2 rooms open, the Chattanooga Endoscopy Center (then named the Digestive Disorders Endoscopy Center) performed 2,173 cases in its 2 procedure rooms, which was an average of 1,087 cases per room.

Currently, its utilization is climbing rapidly, due to expansion of the medical staff (which has almost quadrupled to 15 gastroenterologists) and to the addition of a 3rd procedure room this year:

Table Five: 2015 Escalation of Utilization at the CEC (Calendar Year Data)

	CY Cases	Annualized (Run Rate)	Annual Cases Per Procedure Room
CY2014	2,152		1,076 (2 rooms)
CY2015			
January	172	2,064	1,032 (2 rooms)
February	327	3,924	1,308 (3 rooms)
March	399	4,788	1,596 (3 rooms)
April	414	4,968	1,656 (3 rooms)
State Plan Target	467	5,604	1,868 (3 rooms)

Once the facility reaches 467 cases per month, this will be an annual rate of 1,868 cases per room per year. At that point, the current utilization of the CEC at its present location will meet the 1,867-case criterion. That will probably be reached in the third quarter of 2015, as additional pre- and post-op spaces are completed to remove bottlenecks that are limiting the full use of the third procedure room.

Impact on Other Facilities

Of the 11,442 projected cases in Year One, an estimated 2,152 will be from physicians already on staff in 2014 and using the CEC for their cases. An estimated 9,290 new cases will be brought by the physicians who have been performing cases at

Table Nine-A: The Chattanooga Endoscopy Center (AMENDED ON SUPPLEMENTAL CYCLE)
Primary Service Area Utilization of Ambulatory Surgical Treatment Centers Performing Endoscopies

	2012 Joint Annual Report of ASTC's							
County	Facility Name	O.R.'s	Procedure Rooms	Total Surgical Rooms	Total Cases	Cases Per Surgical Room	GI Endoscopy Cases	GI Endoscopy Cases Percent of Total Cases
Hamilton	Associates of Memorial/Mission Outpatient Surgery Center	4	3	7	11,740	1,677	6,820	58.1%
	Digestive Disorders Endoscopy Center	0	2	2	2,215	1,108	2,215	100.0%
	Physicians Surgery Center of Chattanooga	4	2	6	3,317	553	574	17.3%
	Plaza Surgery Center (last year of operation as ASTC)	4	4	8	3,855	482	463	12.0%
Bradley	The Surgery Center of Cleveland (Novamed in 2012)	2	1	3	4,856	1,619	1,330	27.4%
	TOTAL TENNESSEE PRIMARY SERVICE AREA	14	12	26	25,983	999	11,402	43.9%
	2013 Joint Annual Report of ASTC's							
County	Facility Name	O.R.'s	Procedure Rooms	Total Surgical Rooms	Total Cases	Cases Per Surgical Room	GI Endoscopy Cases	GI Endoscopy Cases Percent of Total Cases
Hamilton	Associates of Memorial/Mission Outpatient Surgery Center	4	3	7	11,491	1,642	6,675	58.1%
	Digestive Disorders Endoscopy Center	0	2	2	2,240	1,120	2,240	100.0%
	Physicians Surgery Center of Chattanooga	4	2	6	3,194	532	599	18.8%
Bradley	The Surgery Center of Cleveland	2	1	3	5,033	1,678	1,494	29.7%
	TOTAL TENNESSEE PRIMARY SERVICE AREA	10	8	18	21,958	1,220	11,008	50.1%
	2014 Joint Annual Report of ASTC's							
County	Facility Name	O.R.'s	Procedure Rooms	Total Surgical Rooms	Total Cases	Cases Per Surgical Room	GI Endoscopy Cases	GI Endoscopy Cases Percent of Total Cases
Hamilton	Associates of Memorial/Mission Outpatient Surgery Center	4	3	7	11,357	1,622	6,417	56.5%
	Digestive Disorders Endoscopy Center*	0	2	2	2,332	1,166	2,332	100.0%
	Physicians Surgery Center of Chattanooga	4	2	6	3,384	564	552	16.3%
Bradley	The Surgery Center of Cleveland	2	1	3	5,350	1,783	2,005	37.5%
	TOTAL TENNESSEE PRIMARY SERVICE AREA	10	8	18	22,423	1,246	11,306	50.4%

Notes: TN case data is patients reported on page 6 of JARs. GA data fromGA Department of Community Health (2014 not yet published).
**DDEC Cases of 2,332 reflect June 2014 letter to TDH correcting the 2,173 cases previously reported in DDEC's 2014 JAR.*

Even with the additional recovery stations, 3 procedure rooms will not be enough to meet medical staff needs.

CEC's physicians have estimated that of the more than 20,000 outpatient endoscopies they already perform annually in Chattanooga, they intend to schedule 11,442 of them at CEC in 2017. At CEC's current capacity of only 3 rooms, it will have difficulty exceeding 2,500 cases per room. CEC's optimal utilization limit will therefore be 7,500 total cases--only two-thirds (66%) of the cases the medical staff wants to perform there.

To identify what number of rooms would be adequate, AmSurg applied a 2,500-case-per-room standard to the 11,442-case target. That identified a need for 4.6 (i.e., 5) procedure rooms--the finished room complement being requested in this application. It is also prudent to have potential expansion capacity, so an unequipped 6th room is included.

Historic and Projected Utilization

Table 9-A above provided historical utilization of the applicant CEC. Table Ten below expands that data to include projections for 2015-2018.

Table Ten: Chattanooga Endoscopy Center
Historical and Projected Utilization 2012-2018

Calendar Year	Procedure Rooms	Cases	Cases Per Room	Annual Utilization Based On AmSurg Optimal Cases of 2,500 / Rm	Percent of State Health Plan Optimal Cases of 1,867 / Rm	Percent of State Health Plan Full Capacity Cases of 2,667 / Rm
2012	2	2,215	1,108	44.3%	59.3%	41.5%
2013	2	2,240	1,120	44.8%	60.0%	42.0%
2014	2	2,113	1,087	42.3%	58.2%	40.8%
2015	3	5,890	1,963	78.5%	105.1%	73.6%
2016	3	7,500	2,500	100.0%	133.9%	93.7%
2017-Yr 1	5	11,442	2,288	91.5%	122.6%	85.8%
2018-Yr 2	5	11,542	2,308	92.3%	123.6%	86.5%

Source: AmSurg management and medical records.

C(II).6.B. COMPARE THE PROPOSED CHARGES TO THOSE OF SIMILAR FACILITIES IN THE SERVICE AREA/ADJOINING SERVICE AREAS, OR TO PROPOSED CHARGES OF PROJECTS RECENTLY APPROVED BY THE HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).

There are no other dedicated endoscopy centers in the Chattanooga area, so Table Twelve below compares this project's CY 2017 charges to the FYE 2014 charges of Nashville and Knoxville endoscopy centers.

Table Twelve: CEC Charges in CY2017 Compared to FYE 2014 Charges at Other Endoscopy Centers in Knoxville and Nashville

Facility	Cases (Patients) Fiscal	Gross Charges	Gross Charges Per Case	Net Revenue	Net Revenue Per case
Digest. Disease Endo. Center (Nashville)	6,162	$9,148,179	$1,485	$5,242,063	$851
Nashville Endo. Center (Nashville)	2,870	$11,209,263	$3,906	$2,128,551	$742
The Endoscopy Center (Knoxville)	8,402	$17,668,336	$2,103	$5,367,724	$639
The Endoscopy Center West (Knox)	4,193	$8,937,499	$2,132	$2,501,911	$597
Associated Endoscopy (Nashville)	5,031	$8,220,082	$1,634	$2,902,350	$577
The Endoscopy Center North (Knoxville)	5,353	$11,650,650	$2,176	$3,018,963	$564
Chattanooga Endo. Center (Hamilton) *	2,332	$4,260,120	$1,827	$1,167,730	$501
THIS PROJECT CY 2017	**11,442**	**$21,685,100**	**$1,895**	**$6,206,020**	**$542**
NV GI Endo. Center (Nashville)	2,594	$2,748,480	$1,060	$1,210,816	$467
Mid-State Endo. Center (Nashville)	2,436	$2,697,619	$1,107	$1,108,610	$455
Southern Endo. Center (Nashville)	2,711	$2,707,995	$999	$1,153,111	$425

*Source: 2014 Joint Annual Reports of ASTC's. (*2014 JAR of CEC is being amended to reflect 2,332 cases/patients as shown in this table.) FYE data reported in the JAR is the only source for comparison.*

The following page contains Table Thirteen, showing the CEC's most frequent procedures performed, with their current Medicare reimbursement, and their projected Year One and Two average gross charges.

SUPPLEMENTAL #1

June 22, 2015
12:58 pm

CHATTANOOGA
ENDOSCOPY CENTER

Lonnie Matthews
TN Department of Health, Joint Annual Report
Div. of Policy, Planning and Assessment
Cordell Hull Building, 6th Floor
425 5th Avenue, North
Nashville, TN 37243

RE: Notification of Inaccuracy on 2014 Joint Annual Report for Chattanooga Endoscopy Center (formerly "Digestive Disorders Endoscopy Center" – State ID: 33642)

Dear Mr. Matthews:

In an effort to achieve full disclosure and correctness, I am writing to inform you of an inaccuracy that was discovered within the 2014 Joint Annual Report for Chattanooga Endoscopy Center (formerly "Digestive Disorders Endoscopy Center" – State ID: 33642).

After review of the period and final reports, the following material inaccuracies were noted:

- Total number of cases performed in all Operating Rooms: 2,173 (*Correction: 2,332 cases actually performed)
- Total number of procedures performed in all Operating Rooms: 4,119 (*Correction: 2,949 procedures actually performed)

Although the amendment period may have passed, we are requesting that you make note in your files of these correct figures from those that were incorrect as reported by previous billing staff in an effort of transparency regarding this data entry.

Please do not hesitate to contact me should you require further clarification or information.

We appreciate your assistance.

Sincerely,

Jillian Wright
Board Chairperson, Chattanooga Endoscopy Center

5b. The applicant's projections appear to be based on the amounts affirmed by the physicians in the attachment. However, the 5 fold increase between 2013 and 2018 is based on only 3 months of hard data which follows what appears to be a 5.6% decrease from 2012-2014. As such, was any consideration given to waiting to file the proposal until a final 2015 utilization amounts to better support the projected utilization?

It was not. The large numbers of cases being requested by the additional medical staff made it clear to AmSurg that immediate action was needed to open a larger facility as soon as possible, no later than January 2017. The third room and expanded support areas were immediately made operational at the present location and demand for space has continued to escalate steeply, as shown in Table Five of the CON application.

5c. The historical & projected utilization in Table 10 on page 43 is noted. Please add columns to the table showing the number of physicians (by year) and the average # of cases per physician.

Table Ten-B (Supplemental): Chattanooga Endoscopy Center
Historical and Projected Utilization 2012-2018 (Calendar Year Case Data)

Calendar Year	Rooms	CY Cases	CY Cases Per Room	MD Staff	Av'ge CY Cases Per MD	Annual Utilization Based On AmSurg Optimal Cases of 2,500 / Rm	Percent of State Health Plan Optimal Cases of 1,867 / Rm	Percent of State Health Plan Full Capacity Cases of 2,667 / Rm
2012	2	2,280	1,140	3	760	45.6%	61.1%	42.7%
2013	2	2,363	1,182	3	788	47.3%	63.3%	44.3%
2014	2	2,152	1,076	4	538	43.0%	57.6%	40.3%
2015	3	5,890	1,963	14	421	78.5%	105.1%	73.6%
2016	3	7,500	2,500	15	500	100.0%	133.9%	93.7%
2017-Yr 1	5	11,442	2,288	15	763	91.5%	122.6%	85.8%
2018-Yr 2	5	11,542	2,308	15	769	92.3%	123.6%	86.5%

5d. TDH has changed the format of the provider JAR to include the # of cases per operating room and procedure room. Please provider this breakout for existing multi-specialty ASCT facilities in the service area for the 2014 JAR reporting period.

Table 9-A(2) Supplemental--FYE 2014 Cases Per Surgical Room Multispecialty ASTC's in Project Primary Service Area

			FY Cases in Operating Rooms		FY Cases in Procedure Rooms	
ASTC	OR's	Procedure Rooms	FY Cases	FY Cases Per OR	FY Cases	FY Cases Per Room
Assoc. of Memorial/Mission	4	3	4,940	1,235	6,417	2,139
Physicians Surgery Center	4	2	2,356	589	1,028	514
Surgery Center of Cleveland	2	2	5,000	2,500	350	175
Total	10	7	12,296	1,230	7,795	1,114

Source: 2014 JARs

6. Section C, Need Item 3 (Service Area Demographics)

The service area is noted. With patient origin of Marion County residents at less than 5% of total projected patients in Year 1, why was this county included? Do some of the new physicians have office practices in Marion county, does the applicant maintain an active marketing presence in the county? Please clarify.

HSDA practice allows applicants flexibility to define a primary service area as counties contributing at least 80% to 85% of the project's patients, in most cases. As shown in Table Seven, page 35, exclusion of Marion County would have covered approximately 80% of the patients; whereas inclusion of Marion County covers almost 84%. So it was reasonably within the applicant's discretion. Marion County also contributes 1-2 patients per weekday, for a total of more than 3% of all patients. It seems reasonable to include it. That county looks to Chattanooga for most of its specialized medical needs.

7. Section C, Economic Feasibility Item 1 and Item 2

7a. Item 1- the Project Costs Chart is noted. Please provide a copy of the tax record for the existing 136,780 SF Riverside Business Center building that documents the calculations provided on page 46 pertaining to the estimated fair market value of the building for CON purposes.

The tax record is attached after this page.

7b. Item 2- the letter from the CFO of AmSurg is noted. Are the amounts and terms that apply to the AmSurg loan for the project contained in the amortization schedule of the spreadsheet that was also included in the attachment? Please clarify.

They are. The amortization schedule, at its top, indicates the amount at a loan term of 60 month at 5% interest. The schedule accompanied the CFO's funding commitment letter.

8. Section C. Economic Feasibility Item 4, Historical and Projected Data Charts
The charts are noted. Please address the items below:

8a. As noted, the utilization (cases) in the Historical Data Chart differs from other parts of the application such as Section C, Need, Item 5. Please clarify. In addition, the applicant also notes on page 55 that the utilization and gross charges is being amended in the 2014 JAR. While it is understood that it will not match the 2014 Historical Data Chart, please briefly describe what is being amended and why.

The differences were from providing fiscal and calendar year data (which differ) in various tables. Those differences have been identified and either clarified or amended in response to your question 5a above and in the four revised pages attached with that response. The Historic and Projected Data Charts showed only calendar year data and were correct.

Page 55 is among the four Table pages that were clarified or changed. It indicates that the applicant has notified the TDH of the need to change the FYE 2014 patients to 2,332, as shown in the revised table. Charge data does not need to be amended. A copy of that correspondence has been attached above.

SUPPLEMENTAL #1

June 22, 2015
12:58 pm

Street Name: Riverside Street Number: 1501 Parcel: Owner: Go Clear

Searching requires only one complete field, but entering more information will narrow your results. Click here for help.

Print Page 1 of 1

Click on the Column Headings to sort accordingly.
Click on the Parcel ID to view the parcel detail.

Parcel ID	*Location*	Owner	Year Built	Total Value	Square Footage	Description	Sale Date	Sale Price	Book Pa
136J A 002	1501 RIVERSIDE DR	TALLAN HOLDINGS CO	1946	$6,300,000	139,080	COMMERCIAL	5/6/1999		5348-06

Print Page 1 of 1

8b. Line 8.a – Management Fees to Affiliates – shows as $48,000 in the CY 2014 column of the Historical Data Chart but the Projected Data Chart is missing an amount for this line item in (although it does appear as $186,181 in the 2017 column of the detail for Other Expenses). Please clarify.

For consistency, attached following this page is a revised Projected Data Chart, page 52R, and a revised notes page 53R, moving the management fee from "other expenses" to line D8a. These pages contain some other very minor adjustments described in response to question 8d. below.

8c. Please also explain the reason for the 4 fold increase in Management fees from 2014 to Year 1. In your remarks, please explain why there is a separate operating cost for billing fees in lieu of this service being included as a part of AmSurg's management fee.

As part of the negotiation to accommodate the new physician owners, AMSURG agreed to dilute ownership from 51% to 35% and a renegotiation of the Management Services Agreement ensued. The management agreement in place at the time was a flat fee of $48,000/year. Due to the dilution from 51% to 35%, AMSURG no longer owns the majority of the entity. In order to ensure that services provided by AMSURG were provided at Fair Market Value, the management services agreement was amended and restated to clarify AMSURG's roles and responsibilities and compensation at 3% of Net Revenue. Because the management agreement will be a percentage of Net Revenue moving forward, it will fluctuate in sync with volume.

AMSURG provides the billing for CEC through a separate Billing Services Agreement at 3.75% of Net Revenue. Billing Services through AMSURG is not part of the standard management agreement, as the means of completing the billing is a Board decision at each facility's local level.

SUPPLEMENTAL #1

June 22, 2015
12:58 pm

PROJECTED DATA CHART-- DIGESTIVE DISORDERS ENDOSCOPY CENTER
(REVISED ON SUPPLEMENTAL CYCLE)

Give information for the two (2) years following the completion of this proposal.

The fiscal year begins in January.

		CY 2017	CY 2018
	Cases	11442	11542
A.	Utilization Data		
B.	Revenue from Services to Patients		
1.	Inpatient Services	$	$
2.	Outpatient Services	21,685,100	22,093,368
3.	Emergency Services		
4.	Other Operating Revenue (Specify) See notes page		
	Gross Operating Revenue	$ 21,685,100	$ 22,093,368
C.	Deductions for Operating Revenue		
1.	Contractual Adjustments	$ 15,171,419	$ 15,459,382
2.	Provision for Charity Care	76,801	78,247
3.	Provisions for Bad Debt	230,860	232,878
	Total Deductions	$ 15,479,080	$ 15,770,507
NET OPERATING REVENUE		$ 6,206,020	$ 6,322,861
D.	Operating Expenses		
1.	Salaries and Wages	$ 1,573,700	$ 1,620,911
2.	Physicians Salaries and Wages		
3.	Supplies	656,384	681,629
4.	Taxes	161,400	161,400
5.	Depreciation	452,137	452,137
6.	Rent	190,367	181,020
7.	Interest, other than Capital	2,977	2,977
8.	Management Fees		
	a. Fees to Affiliates	186,181	189,686
	b. Fees to Non-Affiliates		
9.	Other Expenses (Specify) See notes page	1,094,517	1,131,583
	Dues, Utilities, Insurance, and Prop Taxes.		
	Total Operating Expenses	$ 4,317,663	$ 4,421,343
E.	Other Revenue (Expenses) -- Net (Specify)	$	$
NET OPERATING INCOME (LOSS)		$ 1,888,357	$ 1,901,518
F.	Capital Expenditures		
1.	Retirement of Principal	$ 836,088	$ 877,893
2.	Interest	284,350	242,546
	Total Capital Expenditures	$ 1,120,438	$ 1,120,439
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$ 767,919	$ 781,079

THE CHATTANOOGA ENDOSCOPY CENTER

D9--OTHER EXPENSES	HISTORIC DATA CHART 2012	2013	2014	PROJECTED DATA CHART 2017	2018
Management Fee to AmSurg--New Location	na	na	na		
7301-0000 Linen service	$8,227	$9,391	$7,884	$43,596	$45,273
7305-0000 Medical waste	$423	$31	$870	$4,812	$4,997
7306-0000 Medical specialist fee	$12,000	$12,000	$12,000	$12,000	$12,000
7309-0000 Billing service	$51,173	$39,397	$41,906	$232,726	$237,107
7321-0000 Collection fees	$2,372	$177	$168	$927	$962
7323-0000 Contract services	$13,531	$13,444	$18,438	$101,952	$105,873
7327-0000 Uniform allowance	$1,549	$1,194	$1,359	$7,517	$7,806
7331-0000 GP travel	$4,116	$3,747	$6,486	$35,867	$37,246
7333-0000 LP travel	$1,393	$1,014	$2,827	$15,631	$16,233
7337-0000 Business meals and entertainment	$2,825	$1,549	$4,933	$27,280	$28,329
7339-0000 Office supplies	$8,875	$12,160	$22,501	$124,423	$129,209
7341-0000 Postage	$675	$92	$386	$2,134	$2,217
7343-0000 Express delivery	$328	$302	$1,039	$5,744	$5,965
7347-0000 Telephone	$7,477	$7,250	$6,524	$36,075	$37,463
7349-0000 Dues and subscriptions	$3,192	$3,155	$5,930	$32,789	$34,050
7351-0000 Meetings and conferences	$583	$1,684	$707	$3,908	$4,058
7353-0000 Maintenance scopes	$209	$0	$20,400	$87,483	$90,848
7355-0000 Maintenance other	$3,914	$18,901	$15,356	$65,850	$68,383
7356-0000 Software maintenance contracts	$9,710	$9,478	$16,023	$68,713	$71,356
7357-0000 Advertising	$4,196	$5,019	$8,189	$35,117	$36,468
7361-0000 Donations and contributions	$100	$1,000	$0	$0	$0
7363-0000 Employee recruiting cost	$245	$916	$1,528	$8,450	$8,775
7369-0000 Other operating expense	$9,539	$14,140	$9,172	$39,334	$40,847
7371-0000 Accreditation fee	$3,739			$0	$0
Total other variable expenses				$0	$0
Fixed expenses:				$0	$0
7412-0000 Rent equipment	$1,817	$1,298	$767	$3,289	$3,416
7421-0000 Insurance malpractice	$7,028	$7,352	$6,787	$37,528	$38,971
7422-0000 Insurance other	$4,720	$5,867	$6,204	$26,606	$27,630
CAM PASS THROUGHS				$0	$0
HOUSEKEEPING				$0	$0
7431-0000 Utilities	$3,818	$4,233	$7,077	$30,349	$31,516
8109-0000 Miscellaneous other income	-$369	-$1,982	-$1,273	-$7,037	-$7,308
8201-0000 Loss on disposition of assets	$0	$0	$2,071	$11,453	$11,893
TOTAL	$167,408	$172,808	$226,260	$1,094,517	$1,131,583

8d. Review of the "Other Expenses" detail also revealed significant increases from 2014 to Year 1 (Projected) in amounts of $50,000 or more for several items. Please briefly explain the primary factors for each item noted in the table below.

Other Expense Item	2014 Cost	Year 1 Projected	Estimated Increase
Medical Specialist Fee	$12,000	$66,355	$54,355
Billing Services	$41,900	$231,722	$189,822
Contract Services	$18,438	$101,952	$83,514
Office Supplies	$22,501	$124,423	$101,923
Maintenance Scopes	$16,000	$68,713	$52,713

The only item that was incorrect in the Projected Data Chart--Other Expenses was the Medical Specialist Fee, which should have remained at $12,000. That has been corrected in the revised Projected Data Chart and Notes Page, pages 52R-53R, attached on the preceding pages.

The other expense items in your table will increase significantly, because they are a function of a variable such as case volume, square feet, net revenue, etc., all of which are expanding greatly. The billing service fee is 3.75% of net revenue. Contract services and office supplies were projected per SF. Scope maintenance will increase with the additional procedure rooms which require additional sets of scopes.

9. Section C, Orderly development, Item 7.c

The current licensure by TDH is noted. Review of the May 2014 licensure survey revealed no acceptance letter from TDH for the applicant's plan of correction. Please provide a copy of the letter confirming the applicant's plan of correction was approved.

The TDH approval letter is attached after this page.

SUPPLEMENTAL #1
June 22, 2015
12:58 pm

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
7175 STRAWBERRY PLAINS PIKE, SUITE 104
KNOXVILLE, TN 37914

August 6, 2014

Ms. Kristi Ballard, R.N., Administrator
Digestive Disorders Endoscopy Center
2341 McCallie Avenue
Plaza 3, Suite 303
Chattanooga, TN 37404

Provider # 44-C0001076

Dear Ms. Ballard:

The East Tennessee Regional Office of Health Care Facilities conducted a recertification survey on May 27 – 29, 2014. A Health desk review of your plan of correction for the deficiencies cited as a result of the survey was conducted on July 3, 2014. Fire Safety on-site visit was conducted on July 29, 2014. Based on the reviews, we are accepting your plan of correction and your facility is in compliance with all participation requirements as of July 13, 2014.

If you should have any questions, please contact the East Tennessee Regional Office at (865) 594-9396.

Sincerely,

Karen B. Kirby

Karen B. Kirby, R.N.
Regional Administrator
East TN Health Care Facilities

KBK:cvb

SUPPLEMENTAL #1
June 22, 2015
12:58 pm

10. Proof of Publication

Although referenced in the application, a publisher's affidavit or copy of the newspaper page containing the LOI with date and mast intact was omitted from the application. Please provide this information to confirm publication of the LOI in a newspaper of general circulation in the service area.

Proof of publication is attached following this page.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please FAX or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

SUPPLEMENTAL #1

June 22, 2015
12:58 pm

2879542
AMSURG

STATE OF TENNESSEE
HAMILTON COUNTY

Before me personally appeared Jim Stevens who being duly sworn, that he is the Legal Sales Representative of the "CHATTANOOGA TIMES FREE PRESS" and that the Legal Ad of which the attached is a true copy, has been published in the above said Newspaper and on the website on the following dates, to-wit:

June 9, 2015

And that there is due or has been paid the "CHATTANOOGA TIMES FREE PRESS" for publication of such notice the sum of $383.36 Dollars. (Includes $10.00 Affidavit Charge).

Jim Stevens

Sworn to and subscribed before me, this 9th day of June, 2015.

Amanda Crawford

My Commission Expires 10/17/2018

AMANDA CRAWFORD
STATE OF TENNESSEE
NOTARY PUBLIC
HAMILTON COUNTY
MY COMMISSION EXPIRES OCTOBER 17, 2018

Chattanooga Times Free Press

NOTIFICATION OF INTENT
TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that the Chattanooga Endoscopy Center (an ambulatory surgical treatment center, formerly named the Digestive Disorders Endoscopy Center), owned by The Chattanooga Endoscopy ASC, LLC (a limited liability company), and managed by AmSurg Corp (a corporation) intends to file an application for a Certificate of Need to relocate from 2341 McCallie Avenue Plaza 3, Suite 303, Chattanooga, TN 37404, to the Riverside Business Center at 1501 Riverside Drive, Suite 117, Chattanooga, TN 37406, a distance of approximately 3 miles, and to expand its surgical room complement from three (3) procedure rooms to five (5) procedure rooms, with a sixth room shelled in for potential future expansion. The project cost under CON rules is estimated at approximately $8,624,000, which includes space lease payments for fifteen years and the value of equipment being relocated.

This facility is currently licensed by the Board for Licensing Health Care Facilities as a single specialty ambulatory surgical treatment center limited to endoscopy. The relocation will not change the facility's license classification. The project does not contain major medical equipment or initiate or discontinue any other health service; and it will not affect any facility's licensed bed complements.

The anticipated date of filing the application is on or before June 15, 2015. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
Pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need application must file a written objection with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B) any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

38784308

SUPPLEMENTAL #1
June 22, 2015
12:58 pm

RECEIVED

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY:

Chattanooga Endoscopy Center

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge.

John L Wellborn
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 22 day of JUNE, 2015, witness my hand at office in the County of DAVIDSON, State of Tennessee.

NOTARY PUBLIC

My commission expires 01-11, 2017.

TIFFANY B. POULOSE
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY
MY COMMISSION EXPIRES 1-11-2017

HF-0043

Revised 7/02